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IMPACT OF CERTAIN TAX-RELATED ASPECTS OF THE ADMINISTRATION'S HEALTH CARE REFORM PROPOSAL ON RESIDENTS OF INNER-CITY AND OTHER DISTRESSED NEIGHBORHOODS

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SUBCOMMITTEE ON SELECT REVENUE MEASURES
OF THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRD CONGRESS

FIRST SESSION

NOVEMBER 9, 1993

Serial 103-50

Printed for the use of the Committee on Ways and Means



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- FEDERAL BUREAU OF INVESTIGATION -
DEPARTMENT OF JUSTICE

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CONTENTS

Press release of October 25, 1993, announcing the hearing	2
---	---

WITNESSES

U.S. Department of Health and Human Services: Hon. Phillip R. Lee, M.D., Assistant Secretary for Health; and Peter Edelman, Counselor to the Secretary	11
<hr/>	
American Federation of State, County and Municipal Employees, AFL-CIO, Gerald W. McEntee and Stanley Hill	183
Cabrini Medical Center, Jeffrey Frerichs	98
Columbia University, Herbert Pardes, M.D.; and Cheryl Healton	79
Cooper, Stephen, Hospital Association of New York State	128
Fertel, Stanley, Jewish Memorial Hospital	119
Frerichs, Jeffrey, Cabrini Medical Center	98
Greater New York Hospital Association, Kenneth E. Raske	153
Greenspan, Benn, Mount Sinai Health System	104
Health Insurance Plan of Greater New York, Marc S. Wolfert	159
Healton, Cheryl, Columbia University	79
Hill, Stanley, American Federation of State, County and Municipal Employees, AFL-CIO	183
Hospital Association of New York State, Stephen Cooper	128
Jewish Memorial Hospital, Stanley Fertel	119
Mary Imogene Bassett Hospital, William F. Streck, M.D.	123
McAndrews, Lawrence A., National Association of Children's Hospitals and Related Institutions	188
McEntee, Gerald W., American Federation of State, County and Municipal Employees, AFL-CIO	183
Mental Health Management of America, Thomas P. Salmon	143
Mount Sinai Health System, Benn Greenspan	104
National Association of Children's Hospitals and Related Institutions, Lawrence A. McAndrews	188
Pardes, Herbert, M.D., Columbia University	79
Raske, Kenneth E., Greater New York Hospital Association	153
Salmon, Thomas P., Mental Health Management of America	143
Streck, William F., M.D., Mary Imogene Bassett Hospital	123
Wolfert, Marc S., Health Insurance Plan of Greater New York	159

SUBMISSIONS FOR THE RECORD

American Hospital Association, statement	206
Catholic Health Association of the United States, statement and attachment ..	209
Center on Addiction and Substance Abuse at Columbia University, New York, N.Y., Hon. Joseph A. Califano, Jr., statement	6
Shriners Hospitals for Crippled Children, Tampa, Fla., Gene Bracewell, state- ment	216

IMPACT OF CERTAIN TAX-RELATED ASPECTS OF THE ADMINISTRATION'S HEALTH CARE REFORM PROPOSAL ON RESIDENTS OF INNER-CITY AND OTHER DISTRESSED NEIGHBORHOODS

TUESDAY, NOVEMBER 9, 1993

**HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON SELECT REVENUE MEASURES,
*Washington, D.C.***

The subcommittee met, pursuant to call, at 10:10 a.m., in room 1100, Longworth House Office Building, Hon. Charles B. Rangel (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
MONDAY, OCTOBER 25, 1993

PRESS RELEASE #14
SUBCOMMITTEE ON SELECT REVENUE
MEASURES
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
(202) 225-1721

THE HONORABLE CHARLES B. RANGEL (D., N.Y.), CHAIRMAN,
SUBCOMMITTEE ON SELECT REVENUE MEASURES,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A PUBLIC HEARING ON
THE IMPACT OF CERTAIN TAX-RELATED ASPECTS
OF THE ADMINISTRATION'S HEALTH CARE REFORM PROPOSAL ON
RESIDENTS OF INNER-CITY AND OTHER DISTRESSED NEIGHBORHOODS

The Honorable Charles B. Rangel (D., N.Y.), Chairman, Subcommittee on Select Revenue Measures, Committee on Ways and Means, U.S. House of Representatives, today announced a public hearing on the impact of certain tax-related aspects of the Administration's health care reform proposals on the health and well-being of residents of inner-city and other distressed neighborhoods. The hearing will be held on Tuesday, November 9, 1993, beginning at 10:00 a.m., in the Committee's main hearing room, 1100 Longworth House Office Building.

In announcing this hearing, Chairman Rangel stated: "Now that the Administration has released the outlines of its health care reform proposal, it is appropriate for the Subcommittee to return to its examination of the impact of health care reform, and specifically, certain tax-related aspects of the Administration's proposal, on the health and well-being of residents of inner-city and other distressed neighborhoods."

The Subcommittee will take testimony from invited and public witnesses.

BACKGROUND

The Subcommittee held its first day of hearings on tax issues affecting the health and well-being of residents of inner-city and other distressed neighborhoods on June 29, 1993. At that time, the Subcommittee heard testimony from invited and public witnesses, many of whom had extensive experience in delivering health care to the residents of these communities. They testified to the intricate interrelationship of the problems of economic development, education, health, substance abuse, and violence in the inner city and other distressed neighborhoods. This testimony provided the Subcommittee with a framework by which to evaluate the effectiveness of any proposal for health care reform in improving the health and well-being of the residents of inner-city and other distressed neighborhoods.

On September 22, 1993, President Clinton addressed a Joint Session of Congress to provide the outlines of the Administration's proposal for health care reform. The proposal includes some specific provisions intended to address the unique problems faced by residents of inner-city and other distressed neighborhoods, for instance, tax incentives for providers who agree to work in underserved areas.

In addition, the reform proposal raises questions about the future role of tax-exempt hospitals in distressed neighborhoods because the proposal envisions the elimination of most uncompensated care. Under current law, a hospital's tax-exempt status depends in part on its willingness to provide care to those with limited ability to pay, including Medicaid and Medicare patients, as well as to provide other community benefits. Therefore, it may be appropriate to develop new standards for tax exemption in the case of hospitals and other health care providers who deliver care in the new system.

The Subcommittee invites public testimony on these specific issues.

(MORE)

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD:

Individuals and organizations interested in presenting oral testimony before the Subcommittee on any of the new proposals specifically described herein must submit their requests to be heard by telephone to Harriett Lawler, Diane Kirkland, or Karen Ponzerick [(202) 225-1721] no later than close of business, Monday, November 1, 1993, to be followed by a formal written request to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The Subcommittee staff will notify by telephone those scheduled to appear as soon as possible after the filing deadline. Any questions concerning a scheduled appearance should be directed to the Subcommittee [(202 225-9710)].

Persons and organizations having a common position are urged to make every effort to designate one spokesperson to represent them in order for the Subcommittee to hear as many points of view as possible. Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing (see formatting requirements below). This process will afford more time for Members to question witnesses. In addition, witnesses may be grouped as panelists with strict time limitations for each panelist.

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, all witnesses scheduled to appear before the Subcommittee are required to submit 200 copies of their prepared statements to the Subcommittee office, room 1105 Longworth House Office Building, at least 24 hours in advance of their scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements for the printed record of the hearing should submit at least six (6) copies by the close of business on Tuesday, November 23, 1993, to Janice Mays, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements for the record of the printed hearing wish to have their statements distributed to the press and the interested public, they may provide 100 additional copies for this purpose to the Subcommittee office, room 1105 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee:

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

* * * * *
* * * * *

Chairman RANGEL. The Subcommittee on Select Revenue Measures will now come to order. This morning we will take a look at health reform and how it relates to problems of medically underserved communities and the health problems that they have.

This is the second day of hearings that we will be dealing with the problems of these type of communities. The first hearing was on June 29, and we took testimony from those people who had extensive experience in delivering health care to these types of communities.

We talked about the interrelationship of the problems of economic development, education, health, substance abuse, and violence in our distressed communities. Today we will talk about a framework for providing health care that would improve the quality of health in these communities, and we would like to take a look and see how the administration intends to deal with some of the unique type of problems that we face here.

Those problems, of course, include substance abuse, AIDS, TB, high infant mortality, trauma injuries, low immunization rates, and also to see not whether or not we just have the poor folks have access to health care, but to determine whether or not the goal is to remove them from these particular distressed areas.

In other words, if we were talking about drug addiction, would the provider be concerned about giving methadone over a long period which is relatively inexpensive or is the goal to get the patient into full recovery and into a market, and what standards would you require for providers to have in this area.

The Chair takes a great deal of pleasure in recognizing Mel Hancock, the ranking minority member, for an opening statement.

Mr. HANCOCK. Thank you, Mr. Chairman. Today's hearing will provide an interesting look at the special health care problems of urban and other economically distressed neighborhoods. I understand we are also going to focus on the health care needs of areas of the country which in many respects are very much different from those of our large population centers.

As many of us know, urban poverty places unique pressures on our current health system. Although an adequate presence of hospitals and qualified medical practitioners does not rank first among urban problems, the financial strains of treating the poor is a major problem in many cities across America.

Mirroring those problems are areas like the one I represent which do not suffer the troubles of the big city, but where residents often have to travel long distances to seek specialized medical assistance. It is important for us to examine the administration's health care reform proposals and how well they address the contrasting needs of urban centers and underserved rural areas.

I am also pleased that we will have an opportunity to gather comments on the role of tax exempt and charitable hospitals in the new health care structure which envisions that all medical services are compensated. Thank you, Mr. Chairman, for calling this hearing. I am sure we are going to learn much from the witnesses today.

Chairman RANGEL. Thank you. Before we hear from our witnesses, if there is no objection, I would like to enter the statement of Joseph Califano, Jr. into the record, former Secretary of Health

and Human Services and still doing work at Columbia University in terms of drug and substance abuse, and he would have been with us if he could have rearranged his schedule, but he will be working with the committee members and staff to help us to try to refine the President's package.

[The prepared statement follows:]



Statement of

Joseph A. Califano, Jr.

before the Subcommittee on Select Revenue Measures of the
Ways and Means Committee of the House of Representatives

November 9, 1993

Mr. Chairman:

The hearings you are holding today focus attention on the relationship of drug and alcohol treatment to the President's health reform proposals. Here's how important that relationship is:

Reform of our health system that seeks to provide affordable care to all Americans is doomed to failure unless it mounts an all-fronts attack on substance abuse and addiction.

Substance abuse and addiction is responsible for at least 140 billion dollars of the one trillion dollars we will be spending annually on health care by the end of this year. Some 54 million individuals are hooked on cigarettes; 18-and-a-half-million are addicted to alcohol or abuse it; some 12 million abuse legal drugs; more than six million regularly use marijuana; more than two million use cocaine at least once a week, including half a million addicted to crack; up to a million are hooked on heroin, and the number is growing; half a million use hallucinogens such as PCP and LSD; millions more experiment with illegal drugs. We have in the United States today millions of men, women and children addicted to legal and illegal drugs and alcohol who have not been treated successfully.

Those numbers, grim as they are, cannot convey the human misery--the lives broken, the children killed here in the nation's capital this past Friday night, the senior citizens who lock themselves in their apartments terrified of shopping even in broad daylight, the families destroyed, the babies brought into the world disabled by a parent's crack habit.

Substance abuse is America's public health enemy number one and it requires an all-fronts attack, involving research, education and prevention, and treatment.

Mr. Chairman, your hearing is focused on treatment. Today in America, treatment for the affluent usually means a long term therapeutic or 30-day residential program followed by attentive aftercare. For the poor, it too often means simply transferring the addict to another drug, methadone, without adequate support systems, and giving whatever care underfunded public programs can provide.

What will patients who hold the Clinton administration's Health Security Card get when they go to the doctor, health maintenance organization, clinic or hospital?

The doctor who sees a diabetic has standards to determine whether the patient needs injections of insulin or can take pills. A pediatrician who examines a child with a sore throat, fever and wheezing can determine whether the child has a flu, a cold or a strep throat. Obstetricians have standards to decide whether the delivery can be natural or requires caesarian surgery. A cardiologist can determine whether the heart

condition requires a coronary bypass or an angioplasty. Medicine is still as much mystery as miracle cure, but we have done enough research in each of the areas cited to greatly improve our ability to make the difficult choices so important to the patient's well-being.

What are the standards to guide the physician who sees a drug or alcohol addict? They are inadequate at best. The harsh reality is that we have put work on treatment effectiveness and appropriateness on the back of the medical research burner for the past twenty-five years. As a result, we do not know what treatment works best for whom under what circumstances. What little research we have done is too anecdotal and among groups too small to form the basis for sound general conclusions.

This year, the National Institutes of Health will spend more than four billion dollars for research on cancer, cardiovascular disease and AIDS. NIH will spend less than 20 per cent of that amount on substance abuse and addiction--the largest single cause and exacerbator of those three killers and cripplers.

Skepticism about the effectiveness of treatment is a key reason why the Reagan, Bush and Clinton administrations have not requested the funds needed for treatment--and why the Democratic Congress has given them even less than they asked for.

It is not only a question of need, Mr. Chairman. It is a question of knowledge. At least six million Americans need drug treatment and well over that number need treatment for

alcohol and prescription drug addiction. As a matter of social justice, we must offer treatment to those who seek it--and, indeed, many treatment programs have success rates that compare favorably with many cancer therapies. But until we know better what treatment works best for whom, we are condemning millions of our fellow citizens to lives of degradation, violence, crime and despair.

Our failure to invest the resources to seek more effective treatment for addiction is a national disgrace. If--God forbid--six million Americans had AIDS, polio or multiple sclerosis and millions more were threatened with any of those diseases, does anyone doubt that the Congress would seek a cure by funding a crash research program that would rival the Manhattan Project to harness nuclear power during World War II?

Two years ago, Mr. Chairman, I founded CASA, the Center on Addiction and Substance Abuse at Columbia University. I acted on the conviction that substance abuse and addiction is one of the overarching threats to our nation. CASA's mission is to inform our people of the enormous cost of substance abuse and addiction throughout our society and its impact on their lives, to encourage individuals and institutions to take responsibility to combat substance abuse and addiction and, most relevant here, to find out what works in treatment and prevention.

We are working to conduct a national assessment of what treatment programs work for whom, under the leadership of Dr. Herbert Kleber, one of our nation's finest authorities on

substance abuse and addiction, a man you know. It is our hope that our work will lead the Congress and the administration to invest in treatment the resources we would invest in any other ailment that afflicted so many of our citizens.

Bluntly put, Mr. Chairman, the Health Security Card is a valuable key to health care for millions of Americans with cancer, heart disease, broken bones, respiratory and other socially acceptable ailments. But that card is only as valuable as the knowledge of the doctor and the effectiveness of the treatment he or she has to offer. For patients who abuse substances or are addicted to them, the Health Security Card's currency is greatly reduced until we know what treatment will work best for them.

Chairman RANGEL. Now, we welcome to the subcommittee Dr. Phil Lee, who is Assistant Secretary for Health and our old friend, Mr. Peter Edelman, who is counselor to the Secretary of Health and Human Services, and we will start off with Dr. Lee.

STATEMENT OF PHILIP R. LEE, M.D., ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCCOMPANIED BY PETER EDELMAN, COUNSELOR TO THE SECRETARY

Dr. LEE. Mr. Chairman, thank you very much, and Mr. Hancock, thanks for the opportunity for Peter Edelman and myself to appear before this subcommittee to discuss how the President's health security plan will meet the health needs of America's inner cities, and as Mr. Hancock pointed out, some of the comparable problems are encountered in rural areas, hard-to-reach populations, transportation problems, other access issues.

Although we will not be dealing with those specifically, the plan has a good deal of focus on meeting those needs as well. Mr. Chairman, as you and others in the Congress have been eloquent in speaking out about the health crisis of our inner cities, and I would point out to those who are here, the chairman's statement at the meeting sponsored by Columbia University in June, very eloquent statement, this was a conference on health care in underserved urban America, implications for national health reform.

The Chairman had a very eloquent statement there, and there was also in that a wealth of material that we have been drawing on in terms of our own thinking about the reforms. It was a very, very helpful conference. While we spend more in the United States than any other country in the world, and we have in our cities some of the most renowned public hospitals, some of the most distinguished biomedical institutions, the health status of some of our inner-city residents closely resembles that of citizens of the Third World countries.

The cost of health problems in the urban United States have been staggering, both in terms of human suffering and economically, yet without comprehensive health care reform, it has not been possible to develop an effective proactive strategy for addressing these problems.

The President's plan provides the means for the first time to bring health security to all Americans, including everyone in the inner cities. It does so in part through insurance and market reforms.

More importantly, it actively shifts the focus of the entire health care system toward prevention and strengthens, restructures and integrates the personal care and public health systems. In a culturally diverse environment too often characterized by poverty, overcrowding, crime and unemployment, residents of inner cities suffer disproportionately from an array of health problems.

In my testimony I outline these in some detail, but I would just like to highlight a few. Low-income minority populations in inner cities have as much as a fourfold higher incidence of diabetes, hypertension, heart disease, and stroke than the general population, and often they have less access to care. We know from a study done a few years ago in New York City that what are called discre-

tional admissions, admissions for patients with asthma, for example, much more likely to occur, congestive heart failure or diabetes in low-income neighborhoods.

A recent second study completed in California found it is the lack of primary care in those neighborhoods more than any other single factor that produces the admission to first, the emergency room, then to the hospital. This is one of the areas we will be dealing with in the reforms.

Cancer is diagnosed at much later stages in inner city populations, often when it is no longer treatable. In Harlem, for instance, only 5 percent of women with breast cancer are diagnosed at an early stage as compared with 42 percent of African-American women nationally and 52 percent of Caucasian women nationwide.

Death rates from HIV and AIDS, almost four times as high for African-Americans and two times as high for Hispanics as for Caucasians, again, mainly in inner-city, low-income neighborhoods with multiple other problems. From 1985 to 1992, while the tuberculosis case rate declined from 6.7 to 6.5 cases per 100,000 in nonurban areas in the United States, it increased from 17.1 to 22 cases per 100,000 in urban areas.

Currently New York City accounts for almost 14 percent of the tuberculosis cases nationwide. In Harlem, particularly, the prevalence of tuberculosis is 200 cases per 100,000. That is four times higher than the New York City average. Substance abusers are the fastest growing segment of the HIV-AIDS population, and substance abusers with AIDS are a major factor in the spread of drug-resistant tuberculosis.

The cost of these health problems in the inner cities is high and it is growing. In 1989, for example, the Centers for Disease Control estimated that \$36 million per year would be sufficient to curtail the emerging cases of tuberculosis. Current estimates of need for these activities are now upwards of \$480 million per year.

According to the Center on Addiction and Substance Abuse at Columbia, substance abuse is currently estimated to add \$140 billion to our country's direct and indirect health care costs every year. This would include \$500 million just for the treatment of cocaine-affected infants during the first months of life.

To the extent that health problems of inner-city residents reflect inadequate access to personal medical care, particularly preventive and prenatal care and primary care services, lack of health insurance is certainly a key barrier to access to care in low-income urban neighborhoods, but many have emphasized the importance of other barriers, such as a benefit package that includes preventive services, a comprehensive benefit package.

The second would be proper reimbursement, Medicaid reimbursement for providers, often in inner-city areas has been dismally low as it has been in many rural areas. There has been a shortage of practitioners who are competent and culturally trained, culturally sensitive to practice in those areas. There have been inadequate ambulatory care facilities, whether it is community clinics or outpatient facilities in hospitals, a lack of transportation, a lack of translation services, child care services, and a lack of understanding about access or utilization, adolescents, for example, may have health insurance but don't access mainstream services.

We referred to these as enabling services, services that would provide individuals with access to services above and beyond what is provided when everyone has a card or health insurance. Most of the debate on health care has focused on the personal health care system, but without question the reduced health status of the inner-city populations is related to both a lack of access to personal medical care, but also a decaying public health infrastructure. We have many examples of that.

Currently we are not protecting Americans, and this would be all Americans, sufficiently against preventable infectious disease outbreaks. We are not educating them enough about behavioral and environmental risk factors to their health or protecting their environment against health-threatening exposures. An Institute of Medicine study about 10 years ago found that only about 10 percent of premature mortality could be prevented by access to personal medical care.

About 70 percent related to environmental and lifestyle factors that could be influenced by public health programs. Health problems such as teenage pregnancy, tuberculosis, HIV-AIDS, substance abuse, and violence simply cannot be addressed successfully without vigorous population-based public health activities.

We must define the particular groups for whom problems are most common. We must identify effective interventions by learning why some communities are hard hit by a problem while others somehow seem to escape. We must target public health education and preventive interventions to populations at higher risk and populations with different cultural backgrounds.

We must create alliances between public health agencies, health plans and providers, as well as sectors outside of health, such as public schools, law enforcement, and social service agencies if we are to achieve our health goals.

The close interrelationship between HIV and AIDS, tuberculosis, substance abuse, infant mortality and violence highlights the importance of pursuing integrated approaches that cut across individual problems, and that unite the personal and public health systems.

This morning I would like to go over those aspects of the health security plan that will reduce the disparities in health status for inner-city Americans, both by assuring all Americans access to medically necessary and appropriate care when they need it and by enhancing the ability of communities to protect, preserve, and promote the health of their residents.

For the most part, I will concentrate on the public health initiatives contained in title III of the President's plan. These programs are an integral part to achieve the goals of the health care reform. They will ultimately determine how well health security is provided for all Americans, and the extent to which it will be able to contain accelerating costs of health care. I won't review in detail the basic elements of the plan, but I just want to highlight several factors.

Under reform, all Americans will be covered with a comprehensive range of benefits. Indigent populations will receive subsidies to cover all or part of the costs of their premiums, the cost sharing and in some cases wrap around services. Providers no longer will

receive lower payments when they care for low-income patients. There will also be an additional fund created for vulnerable populations of vulnerable population adjustment, and safeguards will be implemented to prevent discrimination based on race, ethnicity, age or gender.

These include prohibitions against cherry picking and red lining, enforcement of title VI of the Civil Rights Act, requirements that alliances not subdivide metropolitan statistical areas, and the ability of States to require health plans to include inner-city neighborhoods in their service areas.

The access initiative is an important element in the reform as well. This will be a major activity which will include added support for current safety net programs, such as the community and migrant health centers, family planning, Ryan White maternal and child health programs. These will be maintained and, in fact, enhanced.

The practitioner supply available in urban inner-city areas and rural areas will be significantly expanded through ultimately a fivefold expansion of the National Health Service Corps, from a current level of about 1,600, and will also divide those up more equally, about half in the urban inner-city areas and about half in rural areas.

A major part of the access initiative is capacity expansion, and this would permit capacity expansion in inner-city and rural areas with both loan and grant funds. This will be accomplished both by expanding the successful community and migrant health center programs and through a new program supporting the development of community practice networks and health plans.

The new program will integrate federally funded providers with other providers in underserved areas, equipping them with skills to coordinate care, negotiate effectively with health plans, and form their own plans when necessary. It will increase the level of service availability in underserved areas by supporting the creation of new practice sites, and by renovating and converting existing practice sites, including public hospitals and rural hospitals and clinics.

In addition, it will improve access to specialty care in urban and rural underserved areas and improve coordination of care, by linking members of the practice networks with each other and with regional academic medical centers through information systems and telecommunications. That is applicable for the inner-city area and in the rural areas outreach and enabling service, I have mentioned these, transportation, translation, child care, outreach, a significant expansion in the capacity expansion initiative for these enabling services.

There will be an initiative with respect to school age youth, and this is both a school-based health services for adolescents in low-income neighborhoods, primary care nurse practitioners in the schools or in school-related sites, and psychosocial counseling services and social support services.

What students tell us in the high schools particularly, in high risk neighborhoods is they need those counseling services more than any other to help them deal with the problems that they are confronting. That will be provided. The priorities will be for stu-

dents living in neighborhoods or in families where the incomes are 100 percent of poverty or below.

The second part of that school health initiative will be a school health education program to integrate K through 12 education, obviously relating the priorities to local school districts determinations by the local school boards. We are working very closely with the Department of Education on the development of these initiatives to assure that they link closely with their drug education initiatives in the Department of Education and also within our own Centers for Disease Control at the HIV education programs supported by CDC.

Another element in the reform very important is the mental health and substance abuse initiatives in the Public Health Service. We will be expanding both the formula grants for substance abuse and mental health through the Public Health Service in order to provide more enabling services, in order to provide more outreach for the hard-to-reach, hard-core drug addicts or the hard-to-reach, chronically mentally ill such as the homeless mentally ill.

Finally, we have two major initiatives that would support core public health care functions. There are a series of core public health functions that are described in the testimony. I might just illustrate how those core functions would relate, for example, to tuberculosis. It is the Health Department's role, and this would be supported by these core funds, to monitor the incidence of TB cases in the community, and this would permit the Health Department to define exactly where the cases are coming from, what population groups are most in danger of being infected because of their proximity to the sources or sites from which infection arises.

Public health surveillance and monitoring capacity can then define the morbidities, such as substance abuse or HIV-AIDS and make certain that treatment facilities for those diseases are alert to, test for and treat and help control the spread of TB. The public health role is also to control the spread of TB while providing preventive treatments, and for those patients with drug-resistant tuberculosis, there could be supervised drug treatment, multidrug treatment, direct supervision of that treatment by the public health sector or making sure that the plans provide that.

If the plans do it, that is fine. If not, the health departments must do that to protect the health of everyone else. The public health role would be to lead the community-based efforts to prevent tuberculosis spread, convening community meetings that involve housing authorities, homeless shelter organizations, social service agencies, private health care associations, hospitals, and others in the community to mobilize effective prevention programs, and then to educate the community about that.

Finally, there is as part of the public health initiative grants that would go, project grants that would go to State health departments or to local communities and local agencies for public health initiatives at the local level. Violence, for example, prevention initiatives could be initiated with these undifferentiated grants or if a community has a serious problem with diabetes, a diabetes control program. If they want to do a smoking cessation program, different communities may have different priorities.

Finally, two elements in relation to research, particularly the prevention research initiative at the National Institutes of Health will improve our capacity to understand the problems and deal with them more effectively, and a major health services research initiative will help us improve the delivery of services, provide information to practitioners through practice guidelines that will help improve the quality of care that is available by practitioners.

Let me just close with emphasizing that the President's health security plan is designed to provide all Americans, including those living in low-income, inner-city neighborhoods with real health security at an affordable price. To this end the public health initiatives are integral to the success of health care reform.

Taken together these initiatives provide the building blocks vital to meeting the health needs of inner-city residents. They shift financial incentives away from paying for disease and their complications toward paying providers and plans for keeping people healthy. They assure integration of private and public health care providers and mainstreaming of vulnerable populations too long neglected. They build on the new responsibility of health plans and alliances for entire populations by providing funds to States and local health agencies to work in partnership with the personal health care system.

They promote the goal of quality health care and affordable costs by relying more on primary care providers, proven clinical interventions, and strong information base and performance monitoring to support quality assurance efforts.

In summary, the President's health security plan moves away from a two-tiered, inequitable and inefficient system of health care toward a new health-oriented partnership between government, employers, health care providers and consumers, as well as communities.

Mr. Chairman and members, I appreciate, and Peter Edelman appreciates the opportunity to appear before this committee. We look forward to working with you to take full advantage of this opportunity to improve the health of all of our people and to close the gaps between the health status of those in the inner cities and the rest of the population. Thank you, Mr. Chairman.

[The prepared statement follows:]

**TESTIMONY OF PHILIP R. LEE, M.D.
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Thank you, Mr. Chairman, for the opportunity to come before your Committee to discuss how the President's Health Security Plan will meet the health needs of America's inner cities.

Mr. Chairman, you and others in the Congress have been eloquent in speaking out about the health crisis facing our inner cities. While we spend more for health care than any other nation in the world, and have in our cities some of the world's most renowned biomedical institutions, the health status of some inner-city residents closely resembles that of citizens in Third-World countries. The costs of health problems in urban areas of the United States have been staggering, both economically and in terms of human suffering. Yet without comprehensive health care reform it has not been possible to develop an effective, proactive strategy for addressing them.

The President's plan provides the means -- for the first time -- to bring health security to all Americans, including those in inner cities. It does so in part through insurance and market reforms. More important, it actively shifts the focus of the entire health care system toward prevention and strengthens, restructures, and integrates the personal care and public health systems.

THE HEALTH CARE PROBLEM IN INNER CITIES

In a culturally-diverse environment too often characterized by poverty, overcrowding, crime, and unemployment, residents of inner cities suffer disproportionately from an array of health problems. Let me share with you a few examples.

- ◆ Low-income, minority populations in inner cities have as much as a four-fold higher incidence of diabetes, hypertension, heart disease, and stroke than the general population. These chronic diseases are also more likely to be poorly controlled and to be the cause of death in these populations than in other Americans.
- ◆ Cancer is diagnosed at much later stages in inner-city populations, often when it is no longer treatable. In Harlem, for instance, only five percent of women with breast cancer are diagnosed at an early stage as compared with 42% of African American women and 52% of Caucasian women nationwide.
- ◆ Births among girls ages 15-17 are three times higher for African Americans than Caucasians; for girls 14 years of age and younger, the birth rate for African Americans is six times higher. The incidence of low birth weight and infant mortality are both twice as high for African American mothers as for Caucasian mothers.
- ◆ The death rate from HIV/AIDS is almost four times higher for African

Americans and over two times higher for Hispanics than for Caucasian Americans. In 1991, AIDS was the leading cause of death -- ranking higher than cancer and homicide -- among African Americans and Hispanics ages 25 to 44.

- ◆ From 1985 through 1992, while the tuberculosis case rate declined from 6.7 to 6.5 cases per 100,000 in non-urban areas of the United States, it increased from 17.1 to 22 cases per 100,000 in urban areas. Currently, New York City accounts for 14 percent of all cases of tuberculosis in the country. In Harlem, the prevalence of tuberculosis is 200 cases per 100,000, four times higher than the New York City average.
- ◆ Substance abusers are the fastest growing segment of the HIV/AIDS population, and substance abusers with AIDS are a major factor in the spread of multi-drug resistant tuberculosis. Fifteen percent of women delivering babies in Harlem hospital use cocaine.

The cost of these inner-city health problems is high and growing. For example, in 1989, the Centers for Disease Control estimated that \$36 million per year would be sufficient to curtail the emerging tuberculosis epidemic. Current estimates of need for these activities are now up to about \$480 million per year. According to the Center on Addiction and Substance Abuse at Columbia University, substance abuse is currently estimated to add \$140 billion to our country's direct and indirect health care costs every year, including \$500 million to treat cocaine-affected infants during their first month of life. Without effective intervention, HIV/AIDS, teen pregnancy, and chronic diseases will continue to add unnecessary billions to our health care costs.

To some extent, the health problems of inner-city residents reflect inadequate access to personal medical services, particularly preventive, prenatal, and primary care services. Lack of health insurance is certainly a key barrier to care in low-income, urban neighborhoods. But many have emphasized the importance of other barriers, such as benefit packages lacking coverage for preventive services; low Medicaid provider reimbursement rates; a serious undersupply of competent and culturally-sensitive practitioners; inadequate outpatient and inpatient facilities; lack of transportation, translation, or child-care services; and a lack of understanding among certain segments of the population -- such as adolescents, substance abusers, the homeless -- of the need for or availability of health care services.

Most of the health care debate has focused on the personal health care system. But, without question, the reduced health status in inner cities is directly related to our lack of support and attention to public health. Currently, we are not protecting Americans sufficiently against preventable infectious disease outbreaks, educating them enough about behavioral and environmental risks to their health, or protecting their environment against health-threatening exposures.

In 1982, the Institute of Medicine estimated that only 10 percent of preventable early death is related to inadequate delivery of personal medical services, whereas 70 percent is related to environmental and lifestyle factors that can be addressed by public health. In recent years, however, as the health insurance system has failed more and more Americans, public health's energies and resources have increasingly been focused on providing personal health care services to the uninsured and underinsured, to the detriment of its essential, population-based functions.

Health problems such as teenage pregnancy, tuberculosis, HIV/AIDS, substance abuse, and violence simply cannot be addressed successfully without vigorous population-based public health activities. We must define the particular groups for whom problems are most common. We must identify effective interventions by learning why some communities are hard-hit by a problem while others somehow seem to escape. We must target public education and prevention interventions to populations at highest risk and populations with different cultural backgrounds. And we must create alliances between public health agencies, health plans, and providers as well as sectors outside health, such as public schools, law enforcement agencies, and social service agencies. The close interrelationship between HIV/AIDS, tuberculosis, substance abuse, infant mortality, and violence highlights the importance of pursuing integrated approaches that cut across individual problems and that unite the personal care and public health systems.

INNER CITIES AND HEALTH CARE REFORM

This morning, I would like to go over those aspects of the Health Security Plan that will reduce disparities in health status for inner-city Americans, both by assuring all Americans access to medically necessary and appropriate care when they need it, and by enhancing the ability of communities to protect, preserve, and promote the health of their residents. For the most part I will concentrate on the public health initiatives contained in Title III of the President's plan. These programs, which are integral to achieving the goals of health care reform, will ultimately determine how well health security is provided for all Americans and the extent to which we will be able to contain accelerating health care costs.

Basic Elements of Reform

I need not review in detail with this committee the basic elements of the President's plan that will improve access to care for all Americans. However, considering the problems of inner-cities, several points are worth emphasizing:

- ◆ Under reform, all Americans will be covered for a comprehensive range of benefits, including expanded mental health and substance abuse services. In addition, preventive services will be available without deductibles or copayments.

- ◆ Indigent populations will receive subsidies to cover part or all of the costs of premiums, cost sharing, and, in some cases, wraparound services.
- ◆ Providers no longer will receive lower payments when they care for low-income patients. Hospitals serving a high proportion of low-income and undocumented persons will receive additional payments through a federal Vulnerable Population Adjustment.
- ◆ Safeguards will be implemented to prevent discrimination based on race, ethnicity, age, or gender. These include prohibitions against cherry picking and redlining, enforcement of Title VI of the Civil Rights Act, requirements that alliances not subdivide metropolitan statistical areas, and the ability of States to require health plans to include inner-city neighborhoods in their service areas.

Access Initiatives

Congress, including members of this Committee, has demonstrated great concern about the ability of underserved populations to obtain access to personal health care services. You have also expressed concern about the ability of health care providers currently serving underserved populations to become effective participants in the reformed system. The President recognizes, as you do, that a Health Security Card will not, in and of itself, guarantee that all Americans receive necessary health care services. To achieve this goal, universal health insurance must be backed up by an adequate system of practitioners, facilities, education, outreach, and information.

Special initiatives contained in Title III will assure that all Americans -- no matter who they are or where they live -- have access to the full range of services included in the comprehensive benefit package under health care reform. Currently 72 million Americans live in inner-city and rural areas where there are neither sufficient numbers of providers nor adequate facilities. And many isolated, culturally diverse, and hard-to-reach populations confront other barriers that reduce their access to care. The Health Security Act uses five interrelated approaches to remove these barriers to care and to facilitate transition to a single-tier system in which all Americans have an adequate choice of culturally-sensitive providers and health plans.

- ◆ **Current Safety-Net Programs.** Current safety-net programs such as community and migrant health centers, programs for the homeless, family planning, Ryan White, and maternal and child health will be maintained. To assure access and continuity of care during the early years of reform, providers funded under these programs will receive automatic designation as essential community providers, guaranteeing them payment for covered services from all health plans.

- ◆ **Practitioner Supply.** The supply of practitioners in underserved areas will be increased. This will be accomplished by expanding the National Health Service Corps five-fold from its current field strength of 1,600; by redirecting residency training to substantially increase the ratio of primary care physicians to specialist physicians; and by supporting the training of primary care physicians, physician assistants, and advanced practice nurses. Special programs to increase the representation of minorities and disadvantaged persons among health professionals will overcome access barriers that stem from cultural gaps.
- ◆ **Capacity Expansion.** Capacity expansion in inner-city and rural areas will be supported. This will be accomplished both by expanding the successful community and migrant health center program and through a new program supporting the development of community practice networks and health plans.

The new program will integrate federally funded providers with other providers in underserved areas, equipping them with skills to coordinate care, negotiate effectively with health plans, and form their own health plans. It will increase the level of service available in underserved areas by supporting the creation of new practice sites and by renovating and converting existing practice sites, including public and rural hospitals. In addition, it will improve access to specialty care in urban and rural underserved areas -- and improve coordination of care -- by linking members of the practice networks with each other and with regional and academic medical centers through information systems and telecommunications.

- ◆ **Outreach/Enabling Services.** The Access Initiative also incorporates a new competitive grant program that will expand federal support for enabling services -- such as transportation, translation, child-care, and outreach. These grants will assure that isolated, culturally-diverse, hard-to-reach persons not served by other programs get the supplemental services they need to obtain access to medical care and to use the health care system effectively. Awards will be made to community practice networks, community health plans, and other public and private not-for-profit organizations with experience and expertise in providing enabling services for underserved populations, complementing existing Public Health Service programs.

For many years, groups that have been denied access to the traditional medical care system have come to rely on emergency room care, often waiting until their problems are far more difficult and costly to treat. These individuals must be assisted in shifting their care patterns and learning to use the health system more effectively by receiving earlier and more appropriate primary care services. Enabling funds in the new program will not only improve access to care for these vulnerable populations, but will also reduce the

excessive costs associated with avoidable emergency and tertiary care services.

- ◆ **School-Age Youth.** The final component of the Access Initiative will address the problems of one of our Nation's most vulnerable groups: adolescents and young adults. The current health care system has failed to provide our youth with the information and services they need to avoid risky behaviors and make healthy decisions. Adolescents are also often reluctant to seek help, ignorant about what help is needed or where to get it, and concerned about confidentiality. These barriers contribute to the substantial problems with substance abuse, unwanted pregnancy, and HIV/AIDS among this age group.

The Health Security Plan will reach out to school-age youth and adolescents in two ways. The Comprehensive School Health Education initiative will establish a national framework within which States can create school health education programs that improve the health and well being of students, grades K through 12, by addressing locally relevant priorities and reducing behavior patterns associated with preventable morbidity and mortality. This program will be targeted to areas with high needs, including poverty, births to adolescents, and sexually-transmitted diseases among school-aged youth.

The School-Related Services program will support the provision of health services -- including psychosocial services and counseling in disease prevention, health promotion, and individualized risk behavior -- in school-based or school-linked sites. Grants will be made to states for the development and implementation of state-wide projects targeted at high-risk youth ages 10-19. In states that do not take this initiative, grants will be available to local community partnerships including public schools, experienced providers, and community organizations.

Mental Health and Substance Abuse Initiatives

New funds authorized in Title III will assure that low-income, hard-to-reach individuals in inner cities and other neighborhoods know about and take advantage of the expanded mental health and substance abuse treatment benefits included in the comprehensive benefits package. Working through the existing Community Mental Health Services and the Substance Abuse Prevention and Treatment formula grants, these funds will support enabling services -- community and patient outreach, transportation, translation, education -- for low-income individuals and other vulnerable groups (such as the homeless, dually-diagnosed, or severely mentally ill). In addition, they will build up the currently inadequate infrastructure for delivering mental health and substance abuse services in communities and facilitate integrating these services within the broader health care system.

Core Public Health and Prevention Initiatives

Two programs included in Title III will build up the capability of State and local public health agencies to address high priority community health problems. The Health Security Plan, by providing universal insurance coverage, will allow public health agencies to turn their resources and expertise to carrying out the essential population-based functions of public health. At the same time, by supporting the establishment of alliances and health plans, it will enable public health agencies to link with these entities in achieving community-wide health status improvements. The following programs take full advantage of the opportunities inherent in reform to help inner cities and other communities identify, prevent, and control high priority local health problems.

- ◆ **Core Public Health Program.** This competitive grant program will provide funds to State health agencies to strengthen core public health functions at state and local levels. These generic functions, which are essential in addressing the problems of inner cities, such as teen pregnancy, multi-drug-resistant tuberculosis, substance abuse, and violence, include:
 - (1) surveillance of communicable and chronic diseases -- essential to define the magnitude, site, and trends of health problems so that limited resources can be directed to populations at greatest risk.
 - (2) control of communicable diseases and injuries -- essential to ensure that new problems are identified early, that contact tracing and partner notification occurs effectively, and that sources of infectious exposures are removed.
 - (3) environmental protection -- essential to safeguard the physical and social environment (e.g., water, food, housing) against causes of disease.
 - (4) public education and community mobilization -- essential to prevent major causes of premature death and disability that are behavioral in nature.
 - (5) accountability and quality assurance -- essential to ensure against medical and health services that do more harm to health than good.
 - (6) public laboratory services -- essential in the diagnosis of major infectious and environmental threats to health.
 - (7) training and education of public health professionals -- essential to ensure a workforce capable of carrying out public health functions.

The program will foster greater accountability to the federal government for the definition and reporting of progress in achieving public health objectives.

- ◆ **Preventable Priority Health Problems.** A second competitive grant program will provide funds to public and private not-for-profit agencies to address

health issues that affect local communities or specific populations within communities. Many of these problems do not affect the country uniformly and call for tailored, community-based interventions. For example, in some inner-city communities, diabetes or heart disease is a major problem; in others, priority may be accorded to programs that deal with cigarette smoking; while in still other areas, teen pregnancy is an issue of great concern. In cases where multiple factors contribute to a health problem, as with violence, grants will support approaches that cut across individual problems.

Prevention Research

The final components of the Public Health Initiative will support a prevention research initiative in the National Institutes of Health and a health services research initiative in the Department of Health and Human Services. These efforts will provide a knowledge base to prevent disease and promote health more effectively, and to elucidate the factors that affect health care costs, quality, and access.

Prevention research is the foundation for both clinical preventive services and the public health interventions included in the Health Security Plan. Expanded prevention research will ensure the availability of effective preventive measures against existing diseases as well as new and emerging health threats. Progress in preventing disease will help to offset escalating acute health care costs and the disproportionate impact of disease and disability among women, minorities, and the elderly.

Health services research will elucidate what works best in medical care and how to organize providers and institutions most effectively in the new health care system. This investment will build on the considerable expertise of the Agency for Health Care Policy and Research in investigating outcomes and quality research, identifying practice variations with unnecessarily high costs, and developing practice guidelines to improve the appropriateness and effectiveness of the treatment decisions made by health professionals. Further development of these methods will provide more accurate measures to evaluate the performance of alliances and health plans and to assess the extent to which reform is making health care available to all Americans.

CONCLUSION

In closing let me emphasize that the President's Health Security Plan is designed to provide all Americans -- including those living in low-income inner-city neighborhoods -- with real health security at an affordable price. To this end, the Public Health initiatives are integral to the success of health care reform. Taken together, these initiatives provide the building blocks vital to meeting the health needs of inner-city residents. They shift financial incentives away from paying for diseases and their complications toward paying providers and plans for keeping people healthy. They assure integration of private and public health care providers and mainstreaming of vulnerable populations too long neglected. They build

on the new responsibility of health plans and alliances for entire populations by providing funds to state and local health agencies to work in partnership with the personal health care system. They promote the goal of quality health care at an affordable cost by relying more on primary care providers, proven clinical interventions, and on a strong information base and performance monitoring to support quality assurance efforts.

In summary, the President's Health Security Plan moves us away from a two-tiered, inequitable, and inefficient system of health care toward a new health-oriented partnership between government, employers, health care providers, and communities. Mr. Chairman, I appreciate this opportunity to appear before this Committee and look forward to working with you to take full advantage of this unique opportunity to improve the health of all of our people.

Chairman RANGEL. Thank you, Dr. Lee. Most every time we hear a talk or take testimony about the problems of those that live in these medically underserved communities or low-income, minority communities, it seems as though we find clusters of problems that are so closely associated that the costs of dealing with them are really enormous. In other words, you mentioned diabetes, hypertension, heart disease, strokes. Then, of course, Dr. Freeman at Harlem Hospital talks about cancer, and then it is the cost of low weight births, and then there is the problem of HIV and AIDS and tuberculosis is tied in there with the homeless, and the ever complex treatment of drug abusers is tied in with a cap to mental illness.

Then we find from Columbia a report that we add \$140 billion to our country's direct and indirect health care costs every year and \$500 million just to treat the kids born affected by cocaine because of their mother. What are the costs that Health and Human Services have come up with as relates to the amounts of moneys that are pouring into these communities to deal with these types of problems?

Dr. LEE. Currently how much are we spending on the inner-city areas or these problems more generically? On the cost, Dorothy Rice has done a study which I don't think has been published that estimates the costs, for example, of alcohol, drug abuse, and smoking. Those costs, I mean, they are both direct medical care costs and they are indirect costs.

If I remember those figures correctly, they would be in the range of—well, Peter gives me the figures so I can give you the exact figures. Alcohol abuse, these are economic costs which includes the treatment costs, \$99 billion; drug abuse, \$67 billion; smoking, \$72 billion. That is what it costs us as a society for those problems. That is the direct medical care costs as well as the indirect costs of those problems.

Chairman RANGEL. That includes drug treatment?

Dr. LEE. Yes. The direct costs would be—

Chairman RANGEL. Children born addicted to drugs?

Dr. LEE. Right. Correct. Now, the direct costs of those, according to this analysis by Dorothy Rice—Dorothy Rice used to be the Director of the National Center for Health Statistics. She is now on the faculty of the University of California San Francisco and the Institute for Health and Aging and one of the most distinguished people in the country in terms of health statistics and economic analyses.

Chairman RANGEL. Why can't I find out just from HHS how much are you giving to local and State governments in order to deal with these specific problems?

Mr. EDELMAN. Well, Mr. Chairman—if I may, Dr. Lee.

Dr. LEE. Sure.

Mr. EDELMAN. Within HHS what we are spending on drug and alcohol treatment and prevention is approximately \$2 billion, total, including research.

Chairman RANGEL. Now, when you get to all of the other medical problems that these particular communities have, and they are listed by Dr. Lee and then you add to that the contributions of local and State governments, can we come up with a figure as to what

this—I mean, if the whole idea of universal coverage is to try to somehow in the long run reduce the cost, wouldn't it make sense that we at least have some figure about what it costs now?

Dr. LEE. Yes. I could just give you the figures, again, the additional figures on the direct costs, and these would be local governments, State governments, Federal Government, and the Federal Government in some of these areas like drug abuse we are a junior partner.

Chairman RANGEL. I know that. I am trying to find out a figure as to what is the dollar number attached to this because I make up figures as I go along, and no one challenges it, but the problem is that you now are giving me figures of other people, and I assume they have a more scientific way of doing it.

But to be honest with you, in the last administration I said that it was costing us \$500 billion when you include lost productivity and health care and the cost of law enforcement. And the administration said, no, that is wrong. It is \$300 billion a year, so I have been using that. And now I talk with Dick Darman and he says it has increased. It is closer to your original figure of \$500 billion.

I don't know how they do it, but you know how much you are paying and you know what is being matched by local and State governments and so you should come up with a dollar figure that we are investing. So that if we are looking to save money—just take drug abuse, here we have a program that gives access to low or no income drug addicts to get coverage.

Now, are there any criteria as to what is treatment of an addict? We are not into that. We give money to States, but how long. You have a cap on the amount of treatment a drug addict can get.

Now, some people believe that you give them methadone and they take it for all their lives. Other people believe that these addicts aren't looking to be cured, they just want to reduce their habits. Some people believe it is a mental problem they are having. But you now come in and you say, well, listen, you got the card, you got services available, and you have got a cap. I have no idea what concept drives that type of thinking.

Dr. LEE. Well, in the plan there is a drug abuse benefit, a mental health benefit more generous than in most private plans, but the key is this public health initiative building on our public delivery system at the local level for mental health and substance abuse services, and those safety net programs will be continued until such time as we can be assured after the year 2000, or 2000 and whatever, that this approach provides adequate and appropriate care, let's say for the drug addict.

The goal would be obviously to have every person addicted, whether it is to tobacco or nicotine, whether it is to heroin or some other drug, that they would be drug free. For some patients, and that is the goal, that is the treatment approach in many current community-based programs currently. I am most familiar with programs in San Francisco, like the Haight-Ashbury Clinic, for example.

The goal of that program, counseling, psychosocial support, and in some cases they have got a mental illness. They have got depression. Treating that problem helps to overcome the substance abuse or drug addiction factor as well.

The alcoholic, as we know, one of the more successful programs has been AA, social support, motivation for the heroin addict. For some, methadone maintenance has been used, for some methadone and then reducing the doses to get off and be drug free. There are multiple strategies for the treatment of those individuals, and we need to think about that in this reform. Clearly the safety net programs are absolutely critical in this period until we have a fully developed comprehensive system in place, and it is going to differ in New York than it is in San Francisco.

What is needed in different areas? There isn't a cookie cutter that will fit every community to deal with this very, very critical problem, whether it is, as I say tobacco, whether it is alcohol, whether it is illicit drugs.

Chairman RANGEL. Dr. Lee, I am going to pass. I just cannot understand if doctors and scientists can take a look and say you are minority, you are poor, you are homeless, you got tuberculosis, AIDS, and cancer and all these things and you give a guy a card and say but you have got access to health care and then the doctors say, well, we have done our job.

I mean, it just seems to me that if one of these characters walks up to a health provider and says I have got AIDS, I am a drug addict, I am homeless and I have no way of getting a job, but you say, well, here is your card. There must be something when you talk about preventive efforts that deal with why we are spending so much money on these problems, such as \$100 a day for a hotel room for a sick addict, or \$600 a day for some guy that is living in the street with tuberculosis, or \$6,000 a day for a baby being born addicted to drugs?

I mean, some doctor has to say at some point, you know, you have got to stop living this way because all you are doing is spending a lot of money, but you are not on any road to any recovery. Now, I know that may go beyond the scope of a doctor, but if you are in a program designed to save us money and to make people healthier, don't you go to someone else and say this poor son of a gun is going to be sick all of his life unless you take him out of the street, or you can get this jerk rehabilitated or at least drug free, but you know he is unemployable and that is one of the reasons why he drinks and takes drugs.

I mean, is there any structure here that gets you out of the pool, that gets you out of the high risk area? It is OK for me if I am rehabilitated, I will do something else, but if you can never do anything in the beginning and you go there, you get your methadone, how does a provider say I want you out of my plan, I want you healthy and I want you working?

Dr. LEE. Well, the integration, that is one of the things about the President's plan that I think really puts us on the road to dealing with the problem that you have just described. Currently with the current system we are failing miserably to do that. If we continue with the present approach, there is no solution in my view.

Chairman RANGEL. Well, I agree with you there. I just don't know who is in charge of constructing that road, and I can't find anyone that really can tell me what is on that road. All I know is that you are telling me that a drug addict will now have access to treatment and somebody will pay for it, but you really don't know

what kind of treatment he is going to get because each cookie cutter has to take a different view of it.

Dr. LEE. There are different approaches to different individuals, obviously, and we have to have a system that responds to those individual differences and individual needs. The emphasis on prevention, the availability of preventive services, the linkage of the personal medical care system to the public health system permits us or will permit us, I think, to much more effectively deal with these problems.

Now, we are draining local resources that could go into public health and prevention.

Chairman RANGEL. Who is the specialist that handles this for the Secretary? Who understands exactly the goal that we want to achieve because my district probably gets more money than most congressional districts as relates to health care.

I know our hospital people don't want to hear that, but, hell, you know, we got the intensive care money locked up. You get in our hospitals, you are going to be there for a long, long time. We got the money for emergency wards locked up. We got the money for people with gunshot wounds, AIDS, tuberculosis. You talk about it, we get more than our share of Federal dollars.

Now, this is supposed to give me access to more dollars. I want out. I want to know—

Dr. LEE. That is the reason. We want to, first of all, provide primary care at the early preventive point. This plan would do that. It will provide preventive services as part of that. Instead of having—the current focus on tertiary care, it is on specialty care. It is going into the hospital.

If we can provide primary care for that diabetic so that person doesn't have to be admitted or the asthmatic who doesn't have to be admitted, they will get better care. It will be preventive care, and we will reduce the costs in the long term, so I think we are building. There is no single person, but there is a group of us within the Public Health Service and within the Health Care Financing Administration in the department that is really working to integrate and to develop the kind of response that you are talking about.

Chairman RANGEL. Well, is it possible for some Members of Congress that have these problems to meet with your working group and to bring in some of our providers?

Dr. LEE. Absolutely.

Chairman RANGEL. I think that would go a long way in showing you the different approaches that different providers have, and if we are going to have guidelines to make certain that we have enough modalities without—I am not saying without caps, but where caps really have nothing to do with cure, so I yield and we will get together.

Dr. LEE. Very glad to do that, absolutely.

Chairman RANGEL. Very good.

Mr. Hancock.

Mr. HANCOCK. Thank you, Mr. Chairman. You mention Alcoholics Anonymous, which has been very effective in the treatment of alcoholism. Is it not also true, though, that the only person that

has been successful in Alcoholics Anonymous is the one that decides that they want the treatment?

We haven't been able to do anything on alcoholism through Alcoholics Anonymous as far as the general run of alcoholic until they individually decide that they want to quit the abuse of alcohol. Am I correct?

Dr. LEE. Ultimately that is true, but we can provide a lot of support and a lot of information that would assist people in moving into such programs. One of the things the President has emphasized in his plan is individual responsibility, and clearly this is an area. Cigarette moking is another, but you can provide—you can't force somebody to stop smoking cigarettes, but there are lots of things we can do that assist people in that process, but it is ultimately the individual who has to make that decision, just as it is the alcoholic who has to decide that they will no longer drink alcohol because they have a disease that doesn't—they don't tolerate it, and they have to abstain completely.

Mr. HANCOCK. How do we solve the substance abuse problem when the people themselves don't want it solved?

How do you solve it when the people that are using the substances don't want to give up the substances?

Dr. LEE. Well, I can only speak about my experience in San Francisco. I was on the board of a church and actively involved with the church. We had active programs for cocaine-addicted individuals. No question that those individuals wanted to get off crack cocaine. They were addicted, they needed help, and through close cooperation in that case with the Haight-Ashbury Clinic that provided the medical support, we provided through the church the counseling and social support services, in a sense a substitute family, and reached out into the community.

Those programs were quite successful, and there was tremendous motivation on the part of those addicted individuals, but it is not easy when you are addicted to crack cocaine to get off. It is almost—well I won't say impossible by yourself, but it is very, very difficult, and that was a community kind of family approach to it, counseling plus the medical care provided by Haight-Ashbury Clinic, so that I think there is among many individuals very strong motivation, and those are the people we want to help.

Mr. HANCOCK. Thank you, Mr. Chairman.

Chairman RANGEL. Mr. Kopetski.

Mr. KOPETSKI. Thank you, Mr. Chairman. Dr. Lee, I am a prime sponsor of a resolution that would ask for parity between physical and mental health treatment under any kind of universal Health Security Act Program. We have 222 cosponsors in the House for this measure, bipartisan support obviously, well over the 218 required to pass something, and I was very disappointed to see that the President is proposing to discriminate between physical health services under his plan and mental health services.

In all of this discussion that I think the chairman has just done an excellent job of pointing out some of the problems and frustrations in terms of substance abuse and mental health services, people with dual diagnoses with one or the other or both and how they relate to each other. He is right on point in trying to address the

problems of people, be they in the inner-city programs and rural areas for that matter that I have in the great State of Oregon.

Why does the administration take the position that, on the one hand, where they say we have got these huge problems out there in America and they are exacerbated in an urban setting, no doubt about it, and we want to focus on prevention, and yet they put these artificial—he is proposing to put these artificial caps on mental health and substance abuse services.

If we really want to fix the problem and address it today, why are we treating substance abuse and mental health problems differently than a physical injury?

Dr. LEE. Well, I would say, first of all, that the President's proposal really puts all these matters on the agenda and before the Congress. The goal is clearly to provide ultimately equity, just as in the long-term care benefit for the disabled. It is not a comprehensive benefit at this point in time.

On the short term, until we can get the costs of the system under control and the President has proposed, I think, a very appropriate way to do that, until we make the system function more effectively and accountably, at that point we will be able to provide these benefits on an equitable basis.

I think if you try to do that at the outset, as complex as the system is today, one, you would be promising benefits that at the outset you probably couldn't provide fully. Second, that there is enough uncertainty in the delivery of those services. We need more research, which we are supporting in order that we can make sure that those effective services are provided, and I would say that at the next phase, which it will be shortly after the year 2000, that we would be providing those benefits on an equitable basis, so I think that the goal is there. It is simply that at the outset the uncertainties and particularly the costs and the need to get overall costs under control were factors that weighed in those early decisions.

Mr. KOPETSKI. Well, I take great issue with these kinds of statements because I have community mental health programs in my State, and we have been leaders in this area that are begging for more resources. They know what to do, they have the capacity and the ability and the willingness to do this, but they don't have the resources to do it.

If you go to our State hospital in the State of Oregon and knock on the door and say "I need mental health help," they will turn you away, but if 2 weeks later you are a danger to yourself or others, then they will commit you, and that is—you understand this, I am sure, that is exactly what is going to happen. So we know what to do, we have the professionals out there to do it, and you look at cost controls, you go to any jail or prison in this country, and now we are number one in the world.

We have over 1 million people behind bars in this country, and these death penalties and all that isn't going to keep people from committing crimes, and the Brady bill, which I oppose, isn't going to do a thing if it does pass to prevent somebody from picking up a handgun and using it on somebody, but here we are talking, I think, about a real cure, real prevention of preventing somebody

from ever picking up a gun, and you are saying we have to wait 8 years to do that.

Dr. LEE. No, for certain of the benefits, and, for example, the treatment of the chronically mentally ill, a person with depression, for example, can receive regular medical treatments and supervision. There is not a limit on that where there are effective treatments available. There are some limits on the, you know, totality of the benefits.

Mr. KOPETSKI. If you think you have a problem, you are limited in the amount of inpatient or outpatient care under the President's proposal.

Dr. LEE. No question, at this point, it is more of an acute care benefit.

Mr. KOPETSKI. Before anybody develops a chronic mental illness, you are limiting their ability on prevention.

Dr. LEE. Well, I wouldn't quite agree with your assessment of the benefit. I think we do have a very strong preventive emphasis. There is treatment available, there are limits on inpatient, there are some other limits on the benefits, but again I would cite the example of the long-term care benefit. We can do much more—

Mr. KOPETSKI. We are not talking about long-term care.

Dr. LEE. They are comparable problems in terms of the uncertainty in the kind of analysis. I don't think there is any disagreement between us about what we want to achieve and if we could achieve it more quickly. The President would, I am sure, be very, very glad to do that.

Mr. KOPETSKI. Mr. Chairman, you have correctly put on the panel later on I think a group that has worked on managed care of mental health benefits, and we can show that we can have an unlimited benefit and that there can be cost controls in this.

I wrote the First Lady after she testified before this committee about six weeks ago asking her to clarify something she said that she testified to right where you are sitting, and that was whether this phase-in is dependent or not upon a realization of savings internally in the health care plan because we have been led to believe that any phase-in would not be dependent upon realization of internal savings, but what she testified to seemed to suggest something else.

She still has not responded to that letter. If you happen to see her, I know she is a very busy person, but I am busy, too and I would like to be able to come up with a position before I vote on any kind of health care plan on this area, and I hope you would ask her to respond to my 6-week-old letter.

Dr. LEE. We will certainly do that. Also on the managed care side on mental health, we have looked at that very carefully with a number of organizations involved in that. I happen to be a very strong believer in managed care systems for persons with chronic mental illness and with acute mental problems, and I think I share your optimism about the feasibility of managed care controlling the cost and providing comprehensive services. That is, of course, what we hope to do in transforming the system to create these capitated systems that will be managed care systems, and I think that then gives us the capacity to do exactly what you are talking about.

Mr. KOPETSKI. Thank you, Mr. Chairman.

Chairman RANGEL. Mr. Edelman, I understand that you have to return to the White House. Will you have staff remain throughout the hearing?

Mr. EDELMAN. There will be staff here through the day, Mr. Chairman, and I will return at the close of the hearing as we had agreed.

Chairman RANGEL. Very good.

Mr. Hoagland.

Mr. HOAGLAND. Thank you. Let me, Dr. Lee, Mr. Secretary, let me just ask briefly because we do have a vote that has just begun, how confident you are that we can afford the basic plan that the administration has laid out in its proposal?

Dr. LEE. I personally am very confident. I chaired the Physician Payment Review Commission for the Congress for 6 years, resigning when I assumed this position or when I began to consult more actively with the Secretary in January actually. That experience, looking very, very carefully at costs of medical care, and, of course, I have run a policy research institute for the last 22 years at the University of California-San Francisco.

I believe that we can do that. I know that some economists have some questions about it. I look at it from the standpoint of a physician, not from the standpoint of an economist. From that perspective I feel that by providing the comprehensive benefit, by permitting the physician to do what is appropriate without the kind of second guessing and restrictions that we place on them, putting them in organized systems, that—and I have looked at this in California in some detail over the last several years.

I feel very confident that we can achieve that. I know there is disagreement about that.

Mr. HOAGLAND. Do you feel confident that we could add benefits to the plan that the administration has brought forth?

Dr. LEE. Well, I would say ultimately we can. I believe, you see, that organized systems—and you take a place like the Mayo Clinic, provides very high quality care, comprehensively, and their costs for an enrolled individual at Mayo over the last 5 years has been less than the cost of GNP increase. Last year it was only 3.7 percent increase. I think in Medicare our expenditure increases were around 10 percent. So that we see in organized systems, I think, the kind of quality, comprehensiveness that is what we would like to see developed nationally, and I think we are seeing it happen very rapidly in some areas.

Portland is one of the areas where we are seeing very rapid development of strong, competitive comprehensive managed care plans.

Mr. HOAGLAND. Thank you.

Thank you, Mr. Chairman.

Chairman RANGEL. Well, I am glad that you agreed to meet not only with some of the providers, but some of the members because we understand access, but we don't know how to get out of these pools, how to get away from the risk and maybe some of your people can help us with that problem.

Dr. LEE. We would like to work with you and the members, Mr. Chairman. If it would be helpful for some of us to visit your district or the districts of members, meet with people in the district, see

it on the front line. We would be very glad to do that because these are very tough problems, and you and many other members of this committee have tremendous experience dealing, understanding the problems, and we would very much welcome that opportunity.

Chairman RANGEL. Dr. Lee, do you know whether there is any accountability at all as relates to drug treatment? I mean, do you?

Dr. LEE. Is there an accountable system?

Chairman RANGEL. Would you know whether anyone at all, anywhere has a reputation of bringing in those people addicted to drugs and sending out healthy citizens that are ready for productive work?

Dr. LEE. Well, I think there are many examples.

Chairman RANGEL. I know.

Dr. LEE. But they are individual examples.

Chairman RANGEL. Not individuals. I mean that with all of the thousands of programs that you fund, are there some programs that you could recommend?

Dr. LEE. I would say absolutely, yes. When I was president of the Health Commission in San Francisco for 4 years, we had responsibility over all the drug treatment programs in San Francisco, and again there were some very innovative approaches. Haight-Ashbury Clinic was one of those. There were some residential treatment programs.

Chairman RANGEL. In these approaches there was followthrough to find out whether or not the person did or did not go back on drugs?

Dr. LEE. Yes. There is good followup, absolutely.

Chairman RANGEL. Could you name one in the New York City area that there is a followup that you can say 50, 60, 70 percent of the people remain drug-free for 6 years?

Dr. LEE. For New York City I would have to ask Herb Kleber or Joe Califano because they have been looking at that in New York more directly than I have.

Chairman RANGEL. That is so unfair. I have been down here for over 20 years and each time I ask the question, they refer me to someone else. I am talking about somebody that has the responsibility of putting up Federal bucks, and I am saying—I fight for more money. I don't even know what the money is being used for.

All of the directors are terrific people and compassionate and understanding, but I dare not ask them whether the programs work because that would be insensitive.

Dr. LEE. Let us get for you the information on programs in New York City, the outcomes of those programs and provide you with as good a picture as we can, particularly with respect to New York about the successful programs.

Chairman RANGEL. You would be ahead if you could just tell me the name of the person in Health and Human Services that has the responsibility to evaluate the success of any program, San Francisco, New York, anywhere. Would a name come to your mind readily?

Dr. LEE. Phil Lee.

Chairman RANGEL. Who?

Dr. LEE. Myself. Ultimately I would have that responsibility as the Assistant Secretary for Health.

Chairman RANGEL. You have not been around long enough. The Bush administration would always tell me that it was, what is his name, the doctor from Harlem? Benny Prim. You know Benny Prim?

Dr. LEE. Sure, I know Benny.

Chairman RANGEL. Did he ever write a report?

Dr. LEE. He was in charge of the Substance Abuse Treatment Center, well it was an alcohol, drug abuse, and mental health administration, now substance abuse and mental health.

Chairman RANGEL. Is he the one who was supposed to evaluate?

Dr. LEE. That center did support evaluations of treatment programs.

Chairman RANGEL. Are they still doing that?

Dr. LEE. Absolutely.

Chairman RANGEL. Who is in charge of that?

Dr. LEE. The person who is currently in charge of the Substance Abuse and Mental Health Administration is Elaine Johnson.

Chairman RANGEL. Would she be able to tell me what I just asked you?

Dr. LEE. We can certainly ask her, and I will hope that she can. In the President's plan we are going to have accountability in a way that we do not have in the present system.

Chairman RANGEL. OK. Then you have answered me. There is no accountability in the present system, so no one really knows what works and what doesn't work.

Dr. LEE. For individual cases or individual clinics or individual programs we can get data on what works, we can get data on what treatments work in particular situations, you know.

Chairman RANGEL. How do you do that? I don't want to argue, but how do you do that? I have got Joe Califano asking for some millions of dollars so that he can do some research about what is working. I would like to be able to say that is great, Joe, but we don't need that because our Federal Government is doing it, but if you are saying that in the President's proposal there will be accountability, I have to assume that there is none now.

Dr. LEE. The medical care system in the United States today is not an accountable system.

Chairman RANGEL. OK. OK.

Dr. LEE. That is one of the major transformations that will occur in the President's plan. The plans will be accountable because they will be capitated.

Chairman RANGEL. I don't know which plans you are going to fund, which plans you aren't going to fund and neither do you because we really don't have any statistical data to show the success or failure of these programs that we have invested Federal dollars.

Dr. LEE. We have. At the level of organized delivery systems, I mentioned the Mayo Clinic cost experience, at the Kaiser Permanente, they are now producing a report card on the performance of that plan in relation to the health of the population and the people served in that plan.

One of the things we will be doing with the President's initiative is to be able to provide that kind of quality report not only to the Congress but to individuals who will choose one plan or another.

Chairman RANGEL. Dr. Lee, you know, if you have a heart attack and you live 10 years, the treatment was successful. I just want to know that if you have a habit and you go to a clinic, you know, did you go back on drugs and if so, how long were you off, and I just want to know whether that question is just a ridiculous question because I certainly haven't found anybody willing to answer it.

Dr. LEE. Well, I would absolutely assure you, at least from my standpoint it is not a ridiculous question. Obviously, you have to differentiate with the diagnosis of the person who is addicted, is it heroin, is it cocaine, is it alcohol, nicotine, and we have data on different treatments for those different problems.

Chairman RANGEL. It would seem to me that, of course, you would do that, that way you could have different success rates based on the length of time a person was on drugs and what drugs, and it makes sense to me, but if I were addicted and I asked you, you know, where could a big shot like Rangel go and I don't want to be going from clinic to clinic, I get the impression that you would not know where to send me, and that is what bothers me even though we redistribute the money to the States based on what they tell us, but I have no way of knowing whether I am getting a con by these directors or not because they say that is insensitive for me to follow through on any of their patients that has been discharged, so I just go to graduations, and they graduate. I don't know what happens.

Dr. LEE. Well, in San Francisco, and, of course, as you say I haven't been here long enough to really know about each community, but in San Francisco if you came to me and said, Phil, who could I go to with this particular addiction problem, I could certainly find a physician and a facility, both inpatient, outpatient, ambulatory, if you needed residential that would be available. That, I could do in San Francisco. I couldn't do it in New York.

Chairman RANGEL. You just find out who my Phil Lee in New York is and we are halfway there. We will work together.

Dr. LEE. Great.

Chairman RANGEL. I think I am going to miss the vote on the journal because we have a lot of people here and maybe if I had called—let me thank you and—

Dr. LEE. Thanks very much, Mr. Chairman.

Chairman RANGEL. We will be working closely together.

[The following was subsequently received:]



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

DEC 21 1998

The Honorable Charles B. Rangel
House of Representatives
Washington, D.C. 20515-3215

Dear Mr. Rangel:

Thank you for the opportunity to testify on November 9 before the Subcommittee on Select Revenue Measures on the impact of Health Care Reform on residents of inner cities.

In response to your letter of November 16, requesting additional information for the record of hearing proceedings, I am pleased to provide our answer to each question. I apologize for the delay in getting these answers to you. Your questions covered a broad scope and the clearance process was more time-consuming than anticipated.

Please contact my office to reschedule our follow-up meeting as early as possible in January. This will facilitate a fuller discussion and understanding of these important issues, and I look forward to seeing you at that time.

Sincerely yours,

Philip R. Lee, M.D.
Assistant Secretary for Health

Attachment

11**ATTACHMENT****1. QUESTION:**

How do you anticipate licensing or certifying providers of less well-established treatments such as outpatient substance abuse? Is there agreement from a medical point of view as to what is an effective course of treatment in substance abuse cases?

ANSWER:

Licensing and certification of health care providers, both individual providers and organizations or facilities, are currently the responsibility of the States. Under the Health Security Act, this will remain primarily a State responsibility.

As to identifying effective courses of treatment for substance abuse, DHHS is vigorously pursuing research and demonstrations to enhance our knowledge about what works best, for whom, and under what conditions. NIDA and NIAAA both support extramural effectiveness research in this area and all SAMHSA programs require grantees to evaluate the effectiveness of their interventions. The current state of knowledge about treatment of alcohol and drug abuse was summarized in two PHS sponsored reports developed by the Institute of Medicine : "Treating Drug Problems" (1990) and "Broadening the Base for Treatment of Alcoholism" (1989).

The Health Security Act envisions an important Federal role in the dissemination of information to practitioners and consumers about effective clinical interventions. And outpatient substance abuse treatment is one area where the Federal government will take the lead in developing and disseminating clinical practice guidelines. SAMHSA's Center for Substance Abuse Treatment is developing practice guidelines through its Treatment Improvement Protocols (TIPs) program, as is the Center for Substance Abuse Prevention through its Prevention Enhancement Protocols (PEPs) program. Some States are considering monitoring the extent to which providers follow practice guidelines and using this information to license or accredit practitioners and facilities.

2. QUESTION:

It is my understanding that the Administration is continuing to refine the mental health and substance abuse guaranteed benefit. Where is the

Administration with respect to this benefit?

ANSWER:

As you are aware, the original draft of the Health Security Act underwent review and the Bill that was officially submitted to the Congress contained several changes from the version released in October. The refined mental health and substance abuse benefit, which was modified to clarify the President's policy and to respond to actuarial findings, offers a flexible continuum of care that allows health plans to tailor treatment programs to each individual's special needs. From the start, these benefits cover a wider range of substance abuse and mental health services than most insurance plans do today. The Health Security Act also takes sequential steps to extend mental illness and substance abuse coverage over time by proposing a benefit structure which will remove initial limits on inpatient mental health and substance abuse services by January 1, 2001.

Attached to this document is the relevant text of the Health Security Act.

3. QUESTION:

Assuming we can get the hard-core addict into the system for detoxification, do we have any data or experience demonstrating what kinds of follow-up treatment are effective in keeping the addict off drugs? Won't the health care system need to coordinate with other support mechanisms within the community to ensure that the patient does not fall into the same pattern of abuse again?

ANSWER:

DHHS continues to focus on the development of effective treatment for persons with severe addictions to heroin, cocaine and other drugs. The NIDA and SAMHSA AIDS Outreach projects have developed techniques for reaching out to injection drug users who have been resistant to attempts to engage them in treatment.

Several large research projects, such as the Drug Abuse Reporting Program and the Treatment Outcome Prospective Study, have demonstrated the effectiveness of residential, outpatient methadone, and outpatient drug-free treatment for persons addicted to heroin and other drugs. Unfortunately, the state of our knowledge about treatment with hard core addicts does not permit precise predictions about which individuals will succeed or fail in treatment. And the proportion of successfully treated addicts is not as high

as we would like. Consequently, DHHS is sponsoring services research at NIDA and NIAAA as well as treatment demonstration evaluations at SAMHSA to investigate these issues.

One thing that is well established is that persons with addictive disorders tend to deny their addictions, resist entering treatment, require substantial supports simply to remain in treatment, and often require linkages to vocational, educational, and other support services. To meet this need, the Health Security Act authorizes \$1.25 billion over 6 years to assure that low-income, hard-to-reach individuals in inner cities and other neighborhoods know about and take advantage of the expanded mental health and substance abuse treatment benefits included in the comprehensive benefits package. These funds will assist States in providing outreach, transportation, translation, and linkage services to recruit people with severe addictive or mental disorders into treatment and to help retain them in treatment long enough for treatment to be successful.

4. QUESTION:

My experience leads me to believe that just because residents of inner-city neighborhoods have a Health Security Card doesn't mean that residents will actually have meaningful access to the kind of health care that will address their unique needs. For instance, assuming that there are enough available providers to deliver it, how do you envision educating inner-city residents about the need for preventive care?

ANSWER:

The Health Security Act recognizes, as you do, that a Health Security Card may not, in and of itself, guarantee that all Americans receive necessary health care services. To achieve this goal, universal health insurance must be backed up by an adequate system of practitioners, facilities, education, outreach, and information.

The Health Security Act uses six interrelated approaches to remove barriers to care and to facilitate transition to a single-tier system in which all Americans have an adequate choice of culturally-sensitive providers and health plans.

- **Current Safety-Net Programs.** The enabling portions of current safety-net programs such as community and migrant health centers, programs for the homeless, family planning, Ryan White, and maternal and child health will be maintained under reform. To ensure access

and continuity of care during the early years of reform, providers funded under these programs will receive automatic designation as essential community providers, guaranteeing them payment for covered services from all health plans.

- **Practitioner Supply.** The supply of practitioners in underserved areas will be increased. This will be accomplished by expanding the National Health Service Corps approximately five-fold from its current field strength of 1,600; by redirecting residency training to substantially increase the ratio of primary care physicians to specialist physicians; and by supporting the training of primary care physicians, physician assistants, and advanced practice nurses. Special programs to increase the representation of minorities and disadvantaged persons among health professionals will help overcome access barriers that stem from cultural gaps.
- **Capacity Expansion.** Capacity expansion in inner-city and rural areas will be supported. This will be accomplished both by expanding the successful community and migrant health center program and through a new program supporting the development of community practice networks and health plans.

The new program will integrate federally funded providers with other providers in underserved areas, equipping them with skills to coordinate care, negotiate effectively with health plans, and form their own health plans. It will increase the level of service available in underserved areas by supporting the creation of new practice sites and by renovating and converting existing practice sites, including public and rural hospitals. In addition, it will improve access to specialty care in urban and rural underserved areas -- and improve coordination of care -- by linking members of the practice networks with each other and with regional and academic medical centers through information systems and telecommunications.

- **Outreach/Enabling Services.** The Health Security Act also incorporates a new competitive grant program that will expand federal support for enabling services -- such as transportation, translation, child-care, and outreach. These grants will help assure that isolated, culturally-diverse, hard-to-reach persons not served by other programs get the supplemental services they need to obtain access to medical care and to use the health care system effectively. Awards will be made to community practice networks, community health plans, and other public and private not-for-profit organizations with experience and expertise in providing enabling services for underserved

populations, complementing existing Public Health Service programs.

As you note in your question, groups that have been denied access to the traditional medical care system have come to rely on emergency room care, often waiting until their problems are far more difficult and costly to treat. The new outreach/enabling services program is designed to help these individuals shift their care patterns so that they receive earlier and more appropriate primary care services. This program will not only improve access to care for these vulnerable populations, but will also reduce the excessive costs associated with avoidable emergency and tertiary care services.

- **School-Age Youth.** The Health Security Act will reach out to one of Nation's most vulnerable groups -- school-age youth and adolescents -- in two ways. The Comprehensive School Health Education initiative will establish a national framework within which States can create school health education programs that improve the health and well being of students, grades K through 12, by addressing locally relevant priorities and reducing behavior patterns associated with preventable morbidity and mortality. This program will be targeted to areas with high needs, including poverty, births to adolescents, and sexually-transmitted diseases among school-aged youth.

The School-Related Services program will support the provision of health services -- including psychosocial services and counseling in disease prevention, health promotion, and individualized risk behavior -- in school-based or school-linked sites. Grants will be made to states for the development and implementation of state-wide projects targeted at high-risk youth ages 10-19. In states that do not take this initiative, grants will be available to local community partnerships including public schools, experienced providers, and community organizations.

- **Mental Health and Substance Abuse Initiatives.** As we mentioned in our response to question 3, the Health Security Act authorizes new funds to assure that low-income, hard-to-reach individuals in inner cities and other neighborhoods know about and take advantage of the expanded mental health and substance abuse treatment benefits included in the comprehensive benefits package. Working through the existing Community Mental Health Services and the Substance Abuse Prevention and Treatment formula grants, these funds will support enabling services -- community and patient outreach, transportation, translation, education -- for low-income individuals and other vulnerable groups (such as the homeless, dually-diagnosed, or

severely mentally ill). In addition, they will build up the currently inadequate infrastructure for delivering mental health and substance abuse services in communities and facilitate integrating these services within the broader health care system.

In addition to these Access Initiatives, the Health Security Act incorporates several other strategies to promote the delivery of preventive services to residents of inner cities.

It encourages health plans to focus their energies on keeping their enrollees healthy by:

- including preventive services (without cost-sharing) in the comprehensive benefits package;
- using report cards to focus attention of health plans on providing preventive services (such as immunization) for their enrollees and to monitor how well they do in this regard; and
- incorporating a payment system (i.e., a fixed annual risk-adjusted premium covering total patient care) that rewards health plans financially for assuring that their populations are aware of and get the preventive services they need to stay well.

The Health Security Act also builds up the capabilities of communities to educate the public about the need for preventive services by providing additional funds to States to support local community education and mobilization campaigns and by creating a new program that provides public and not-for-profit agencies with grants to address local preventable health problems.

There is evidence that these types of approaches can succeed. The Harlem Hospital in New York City has recently concluded a very positive pilot test, using Public Health Service materials developed for the "Put Prevention into Practice" public education program. This pilot used educational materials and clinic-based approaches to deliver the same package of clinical preventive services contained in the Health Security Act's benefits package to the Hospital's low-income population.

5. **QUESTION:**

Some of the special health problems of inner-city residents require a

substantial amount of outpatient followup. How does the Administration anticipate ensuring that a patient with, for example, TB actually take necessary medications for six months? Won't the inner city provider really need a social worker to visit the patient regularly? What if the patient does not speak English? How does the Administration's Health Security Act address these needs?

ANSWER:

As you note, some medical conditions require more than the simple provision of medical services. That is why, in addition to insurance coverage, the Administration's proposal includes additional federal support for enabling services -- outreach, transportation, translation, non-medical case management, linkage to social services -- which are critical to assuring that isolated, culturally diverse and hard to reach populations get the care they need.

Equally important, through both the Core Public Health Program and the Preventable Priority Health Problem programs, the Health Security Act actively strengthens our capacity to provide population-based public health activities. In the case of tuberculosis, that means additional funds to:

- monitor the incidence of TB cases -- defining exactly where the cases are coming from and what population groups are most in danger of being infected;
- control the spread of TB -- helping health plans provide preventive treatment (under supervision when warranted), and tracking down contacts who may be infected for testing and treatment;
- lead community-based efforts to prevent the spread of TB -- convening community meetings that involve housing authorities, homeless shelter organizations, social service agencies, private health care associations, and hospital personnel to craft effective interventions; and
- educate the public about TB -- getting the word out about testing and infection control to groups most likely to be exposed.

6. QUESTION:

How does the Administration's individual responsibility for helping finance

health care costs relate to the realities of the public health system in our cities?

ANSWER:

The Health Security Act includes \$20 billion in new Federal funding for Public Health initiatives such as those described in response to Question 4. New public health funds will flow to state and local areas to improve epidemiological surveillance, research, and workforce programs and to support public health prevention and enabling services. Financing for these initiatives will flow to states and local public health programs through federally authorized grants.

Currently, the Public Health system provides select personal health care services for the uninsured, and other targeted populations. The Health Security Act will for the first time guarantee all Americans a comprehensive set of personal health benefits and will enroll them in mainstream health care delivery systems for their personal health care services. This will help free the public health system to focus on population based health.

With respect to individual responsibility, the President believes that all Americans should take responsibility for helping finance health care to the extent they are able to contribute. The plan adjusts individual premiums and co-payments to take account of personal financial situations.

QUESTIONS FROM DR. BROWN

1&2 QUESTION:

Will disadvantaged groups find fair and effective representation on health alliance boards?

ANSWER:

The Health Security Act states that the Alliance Board of Directors is comprised in equal proportion of members who represent employers whose employees purchase coverage through the alliance, and individuals who purchase such coverage.

3. QUESTION:

Will inner-city residents be the informed and cost-conscious citizens the plan aims to encourage? How will bureaucratic obstacles be reduced so that they can surmount them?

ANSWER:

Inner-city residents who have been uninsured or underinsured may not currently be well prepared to make cost-effective choices about health care. A key to health care reform's success will be reaching out to these people and assisting them as they seek and receive health care. Active consumer participation in the health care system is supported in many ways in the Administration's plan:

- Alliances are required to make available to all eligible enrollees, in easy-to-understand and useful forms, information about plans, including costs, participating providers and their characteristics, and quality measures.
- Alliances are required to conduct educational programs in cooperation with regional professional foundations to assist consumers in using quality and other information in choosing among health plans.
- Information on health plans must be distributed to the entire market, not just to subsets. All consumers in a market must have access to the same information. Marketing information prepared by plans must be approved by the Alliance in order to avoid misleading consumers.
- Those individuals who do not enroll during the annual enrollment period will be enrolled when they present for health care services. Providers will be required to notify alliances who will in turn provide unenrolled persons with information about available choices. If these individuals still fail to choose a plan within 30 days, alliances will be required to enroll them in a health plan.

4. QUESTION:

Will inner-city residents be forced into low-cost plans because they can afford no other?

ANSWER:

Individual discounts under the Health Security Act are targeted to the average-weighted premium rather than to the lowest-cost premium.

Consequently, inner-city residents will not be restricted to the least expensive plan. SSI and AFDC recipients can choose among all plans that are "average" or lower in cost in their service area and be responsible only for their copayments. The working poor, up to 150 percent of poverty, will also be eligible for discounts on their insurance premiums.

The Access Initiatives described in the answer to question 4 are designed to ensure that inner-city residents have an adequate choice of culturally-sensitive providers and plans from which to choose. These programs will increase the supply of practitioners (including minorities) in inner-city areas, increase the number of practice sites, renovate and convert substandard inpatient and outpatient facilities, and support the development of community-oriented practice networks and health plans.

In addition, the essential community provider provisions will assure that federally-funded providers in inner-city areas receive payment from all health plans. This will assure that no matter which plan they choose, residents in inner-city neighborhoods have continuing access to practitioners with experience meeting their special needs and can obtain care in sites convenient to where they live.

5. **QUESTION:**

Will tightly managed care work well for whole segments of inner city populations?

ANSWER:

Under the Health Security Act, States will have the option of implementing a single payer system. For those who do not, a wide range of alternative plans must be made available through alliances, including at least one fee-for-service plan and various forms of managed care, from closed-panel HMOs to different types of preferred provider organizations. In selecting plans, people will be able to choose the type of health care arrangements they believe will best fit their needs. They will not be restricted to "tightly managed care" plans, although such plans may serve many people well by providing their enrollees with linkage to a primary care provider, well-coordinated care, case management services, and an emphasis on preventive care.

The Health Security Act incorporates various strategies to ensure that practitioners with experience and expertise in taking care of inner-city residents become integrated into health plans. The essential community

provider program will assure that these providers receive payment for covered services from all health plans. This, in turn, will assure inner-city residents access to these providers regardless of the health plan they choose.

The new Community Practice Network and Health Plan Program will help federally-funded providers by: linking them with other inner-city providers; bolstering their skills to take on risk and negotiate with health plans; supporting the development of new practice sites (including community health centers, family planning clinics, etc.) and refurbishing existing ones; and providing them with information systems to hook them up with other providers in inner-city areas and with academic medical centers.

6. QUESTION:

If every inner-city resident has a health security card by this time next year, how different will their patterns of care-seeking and receiving be?

ANSWER:

We cannot predict with certainty exactly how care-seeking behavior will change under health care reform. However, because of the way the Health Security Act restructures the personal care system and because of its comprehensive Access initiatives, we expect that inappropriate use of hospital emergency rooms will decrease, that patients will seek care earlier in the course of an illness -- before a small problem becomes a large one -- and that use of preventive services will increase.

The Health Security Act will facilitate these changes by providing all Americans with comprehensive benefits, including preventive services without any cost-sharing. Through the report card and the annual risk-adjusted premium, it will provide health plans with cost and quality incentives to provide primary care and preventive services that keep people out of emergency rooms and other costly care settings.

The Health Security Act contains provisions to ensure that newly-insured people in inner cities have convenient and culturally-sensitive sources of medical care. As noted above, the President's proposal will establish practitioner networks in inner cities, and provide additional support for enabling services, such as transportation, outreach and translation, so that residents have a choice of plans and providers near where they live. We expect community networks to play an important role in educating patients in how to use the health care system effectively.

7. QUESTION:

What special accommodations will be made to enroll the urban poor?

ANSWER:

As noted in our response to Dr. Brown's third question, the Health Security Act contains general provisions to facilitate enrollment in health plans (including point-of-service enrollment) and to provide all residents of alliances with useful, easy-to-understand information to choose among health plans.

Nonetheless, it is likely that special populations, such as the urban poor will require special services to help them use the new system effectively. Community-based organizations and essential community providers could play important roles in this regard. Funds from the new enabling services program will be available to support them in these efforts.

8. QUESTION:

What special efforts will be made to inform people about choices offered?

ANSWER:

See answer to Dr. Brown's third question.

9. QUESTION:

Will there be true incentives to enroll the sickest patients?

ANSWER:

Under the current system, insurers are able to exclude high-risk individuals. Under the reformed system, plans will not be able to exclude anyone on the basis of a pre-existing condition. Enrollees are free to choose, plans must accept, and alliances must enroll all such individuals.

Although the premiums that employers and individuals pay into the system will be community rated, the fixed annual premium that health plans receive will be risk-adjusted according to a methodology to be developed by the National Board. This risk adjustment will take into account factors such as

demographic characteristics, health status, geography, socio-economic status, the proportion of enrollees who are SSI and AFDC recipients, and special problems such as mental illness. This will minimize the financial disincentive that health plans might otherwise have to deny sicker patients costly health services.

In addition, States may provide health plans with incentives to enroll and serve disadvantaged groups. For example, States may modify the risk adjustment methodology or offer other financial incentives to encourage health plans to enroll individuals from disadvantaged groups or provide services such as outreach and transportation to ensure access to care.

The health information system and the program of performance monitoring overseen by the National Quality Management Council will provide a mechanism to monitor the extent to which the sickest members of the population get access to appropriate care.

10. QUESTION:

How will enrollment abuses be prevented (i.e. avoiding very sick, homeless or mentally ill patients)?

ANSWER:

As described in our answers to Dr. Brown's third and ninth questions, the President's plan contains a variety of safeguards to prevent the abuses that characterize the current system.

Under the Health Security Act, enrollment is controlled by the Alliance, not the individual health plan. Information on health plans must be distributed to the entire market, not just to carefully selected subsets. All consumers in a market must have access to the same information. Alliances will review marketing information prepared by health plans to prevent the distribution of false or materially misleading materials. Antidiscrimination provisions will safeguard against cherry picking and redlining. Should plans not be able to enroll everyone seeking membership, regional alliances are responsible for establishing mechanisms to assure continuity in health plan coverage.

Additional policies in the Health Security Act are designed to assure that health plans provide appropriate care for all of their enrollees, including those who require costly services and those who are difficult to reach. These policies include risk-adjustment of plan premiums, the capacity expansion and enabling services programs, the system of performance monitoring

overseen by the National Quality Management Council, and the strengthened role of State and local public health agencies.

11. QUESTION:

What mechanisms will insure that health alliances are responsive to community needs?

ANSWER:

There are mechanisms throughout the President's health reform plan to assure that plans and alliances are responsive to individual and community needs. Each alliance must have an ombudsman office to assist consumers to deal with problems that arise with health plans and the alliance. The alliance will be expected to monitor problems as they arise and deal with them quickly.

Information on each health plan's performance and on a range of national performance measures will be publicly available each year. Indicators will include measures of access, appropriateness of services provided, outcomes of service, health promotion and prevention, and user satisfaction. Alliances, plans, and consumers will be able to identify plans which perform well and those which perform poorly. Individuals will have an opportunity each year to switch plans if they are dissatisfied with their current plan.

States will oversee alliances and certify their health plans. They will ensure that there is access to an adequate selection of health plans in each alliance and can offer incentives to ensure that disadvantaged populations are enrolled and served.

12. QUESTION:

What mechanisms will be used in the inner city to protect quality of care?

ANSWER:

The Health Security Act establishes a performance-based program of quality management and improvement, focusing on appropriateness, effectiveness, and access to health care services. A National Quality Management Council, under the direction of the National Health Board, will be responsible for developing indicators to assess health plan performance in these areas, developing standards, and evaluating the impact of these indicators and

standards in improving quality of care.

Key to the success of this program is the establishment of a Health Information System, which will provide accurate, timely, and comparable information to assess access and quality of care. Because this system incorporates enrollment data, encounter data, consumer surveys, and other information collected by the National Quality Management Council, it will facilitate analyses of both access to health services and outcomes of care for different population subgroups. Analyses will pay special attention to vulnerable populations, such as inner-city residents and consumers who fail to enroll or disenroll from a health plan.

The National Quality Management Council will establish and oversee regional professional foundations, which will conduct continuing education and disseminate quality information to plans and health care providers. The foundations must include at least one Academic Health Center, which is often a primary source of care in the inner cities. In addition, schools of public health, health plans, providers and members from regional and corporate alliances are eligible for membership.

States will be responsible for certifying regional alliance health plans based on quality, ability to deliver the comprehensive benefits package, and financial stability of the plan. Health plans are restricted from redlining geographic areas.

13. QUESTION:

What mechanisms can we develop to provide more emergency coverage for undocumented aliens?

ANSWER:

The Health Security Act retains the Medicaid program provisions that pay for emergency services for undocumented people. Under these provisions, emergency services delivered in hospitals to undocumented people will be reimbursable by state Medicaid programs with continued Federal Medicaid participation.

14. QUESTION:

How can we be certain that health reform advances basic research on the most pressing problems facing our urban poor such as AIDS, sickle cell

anemia, tuberculosis, and substance abuse?

ANSWER:

Title III of the Health Security Act authorizes \$2.9 billion in new biomedical and behavioral research on health promotion and disease prevention. The Act identifies as priorities research on child and adolescent health conditions, reproductive health, mental health, elderly health, substance abuse, infectious diseases, health and wellness promotion, and environmental health.

Within these priority areas, the following issues have been identified as likely to receive additional funding: teenage pregnancy, environmental toxins, HIV prevention, and TB prevention.

The Administration is committed to assuring that these additional prevention research dollars improve the health of the population and reduce the burden of preventable disease.

15. QUESTION:

How can we make certain that the health delivery system accommodates the importance of clinical research?

ANSWER:

Translating the findings of clinical research into practice is crucial to assuring the quality, appropriateness, and cost effectiveness of clinical interventions. The President's plan works to promote clinical research as well as the diffusion of research findings to the practicing community in a number of ways.

First, the National Quality Management Program will include an expanded commitment to the development, dissemination, and evaluation of clinical practice guidelines. Practice guidelines play an important role in educating practitioners on the appropriate use of the latest clinical management options available to them.

Second, Regional Professional Foundations will be established by the National Health Board to disseminate information about health care quality improvement approaches and research findings.

Third, academic health centers, where much of clinical research goes on, will receive additional support to assist them in the additional costs of carrying out research and teaching.

Finally, quality report cards will be available to consumers about plan performance. This information will be made available through alliances and will include performance indicators developed by the National Quality Management Program (NQMP). In developing these indicators the NQMP will take into account recent findings from clinical research.

16. QUESTION:

How can we foster further investment in the systematic search for efficacious and cost-effective clinical interventions?

ANSWER:

The National Institutes of Health have played a leadership role in identifying new and effective therapies for medical conditions. By expanding our investment in prevention research we will balance our commitment to developing new medical treatments for disease with new knowledge on the causes and progression of disease.

Health services research also plays a critical role in evaluating the application of new clinical interventions in the field, to assure that their projected efficacy is realized in all settings and by all populations. By expanding investments in health services research the Administration is demonstrating commitment to assuring that information on how to best organize, structure, and deliver cost effective services is readily available to consumers, health care providers and decision makers at the plan, alliance, state, and national level.

QUESTION FROM DR. GREENSPAN:**B2. QUESTION:**

One of the later witnesses, Benn Greenspan, President of the Mount Sinai Hospital in Chicago, stated that "health reform must support those additional services that are needed to actively engage patients in a system of care" if we are to improve the health status of residents in underserved communities. He gave two examples of such programs operated by his hospital, one serving young girls in grade school who are at risk of becoming pregnant, and one called Fresh Start, serving substance-abusing pregnant women. What does the President's Health Security Act do to encourage the development of, and provide ongoing support for such services?

ANSWER:

Providing comprehensive personal health care coverage that includes preventive services and health education is an essential and central part of the President's plan. Two specific provisions of the President's plans will help enhance the development and delivery of services to residents in underserved areas as described by Mr. Greenspan:

(1) Title III, subtitle E of the Health Security Act establishes new federal programs that will improve access to health services for urban and rural medically-underserved populations by expanding capacity and supporting the provision of enabling services. Grants under these programs will support the development of community-oriented practice networks and community health plans that will provide residents of inner cities and other underserved areas with a choice of culturally-sensitive providers and health plans. These programs will also develop new practice sites, renovate and convert substandard facilities, link providers in underserved areas with each other and with medical centers through information systems, and support the provision of enabling services, such as transportation, community and patient outreach, patient education, and translation services.

(2) Title III, subtitle H of the President's health care reform proposal establishes two new Federal programs to support school-related health education/prevention efforts for children and increase access to services for adolescents in low-income, high risk communities. Under this program, grants will support State and local community efforts to design and implement comprehensive school education programs in grades K-12, as well as school-related health services youth aged 10-19. The comprehensive school health education program will provide \$50 million annually beginning in fiscal year 1995 for grants to States and local

communities. The school-related services proposal will provide \$100 million in fiscal year 1996 growing to \$400 million by the year 2000 in grant funding to States and local communities to provide a range of health services to adolescents.

(3) Title III, subtitle D of the Health Security Act provides State or local agencies and private, nonprofit organizations with funds to develop and implement innovative community-based strategies to promote health and prevent disease. Projects in this program will be targeted to the most needy and vulnerable population groups and geographic areas of the country.

B3. QUESTION FROM STANLEY FERTEL:

Another witness, Stanley Fertel of Jewish Memorial Hospital in Roxbury, MA, expressed concern that the role of long-term care hospitals in serving the needs of medically underserved urban residents (crack babies, young trauma victims requiring care for life) is not fully recognized by the Administration in its health reform plan. How would you respond?

ANSWER:

Importantly, for the first time, every American will be enrolled in a comprehensive health care plan and be entitled to all services described in the guaranteed benefit package. Supplemental services not included in the comprehensive benefit package (referred to as "wrap-around services") will be available to many low-income children and adults. Regardless of whether a person is born with a disability or acquired one later, rehabilitation services are available to all individuals following an acute episode.

The President's plan also recognizes the special long term care requirements of disabled individuals. The Health Security Act covers physical, occupational, and speech/language therapy services for people who experience birth disorders or congenital conditions. The Act will expand home and community-based services to individuals with severe disabilities, without regard to income or age and states will have the flexibility to design and define their community-based service systems.

B4. QUESTION FROM THOMAS SALMON:

Thomas Salmon testified on behalf of the contractor that is providing the mental health and substance abuse benefit to the Medicaid beneficiaries in Massachusetts. Do you anticipate that the mental health and substance

abuse benefit that is part of the package of benefits proposed to be guaranteed by the Administration would be delivered in a similar way? How do we ensure that the most appropriate medical treatment, and not just the least expensive, is provided to our low-income citizens?

ANSWER:

Under the President's plan, the organization and delivery of covered services are the responsibility of the health plans. Some plans may choose to organize and deliver MH/SA services in a manner similar to the managed care program recently initiated by the Massachusetts Medicaid program. Others may not.

Regardless of the details, several features of the President's plan should help ensure that the care delivered is appropriate for all citizens with mental health or substance abuse problems. First, unlike the current situation with Medicaid, all citizens regardless of income will receive care from the same health plans, helping to eliminate the problems caused by low Medicaid payment rates or the dilemma of low-income individuals without coverage of any kind. Second, the design of the initial MH/SA benefit encourages health plans to provide services of the type that have been found to be effective alternatives to inpatient care, such as intensive outpatient services that can often be provided in less restrictive, community-based settings. Finally, several features of the plan help ensure that individuals have appropriate access to quality services. A National Quality Improvement program is initiated, a grievance process is provided for by the plan and the regional alliances must provide ombudsmen for complaints.

B5. QUESTION FROM KENNETH RASKE:

Could you respond to criticism of Kenneth Raske of the Greater New York Hospital Association that the amount of Medicare and Medicaid cuts proposed by the Administration far outweigh the amount of benefits of the Administration's plan for New York City hospitals, many of which are academic centers and disproportionate share hospitals?

ANSWER:

It is important to view the Medicare and Medicaid proposals in the context of health care reform. The proposed payment changes to Medicare and Medicaid in the Health Security Act are part of a comprehensive, competitively-based approach to expanding coverage while reducing the overall rate of growth in health spending.

While Medicare DSH payments will be reduced, they will continue at a level that should be sufficient, given the virtual elimination of the uninsured population which has been a large part of the rationale for the DSH program.

Medicaid DSH payments will be replaced, at a lower funding level, by the Vulnerable Population Adjustment (VPA) program. This new program is designed to offset the residual costs associated with caring for high-cost, low income populations.

There is also a strong commitment in the plan to continue support for the excellent teaching facilities and academic health centers in New York and throughout the country. Under our plan, all payers will contribute to a national pool to finance research and graduate medical education.

While we are continuing our assessment of the impact of the entire package of proposals on specific areas, we know that total Medicare payments to hospitals will increase, not decrease, under health reform. Projections by the Health Care Financing Administration's Actuary show that under health reform, aggregate Medicare inpatient payments to hospitals will increase by about six percent a year from 1994-2000.

B6. QUESTION FROM GERALD McENTEE:

Gerald McEntee testified on behalf of AFSCME that the Administration's health reform plan could have a detrimental effect on its members who staff the public hospitals of this nation. Has the Administration taken into account the effect that a smaller health care workforce will have on jobs in inner-city neighborhoods?

ANSWER:

Yes, these issues have been considered and we see no reason to anticipate that inner-city hospitals will lose jobs under the Clinton plan. Indeed, inner-city neighborhoods will receive a large infusion of dollars under the Clinton plan because poor, currently uninsured residents would now have insurance coverage. These dollars will flow to providers in those areas increasing cash-flow and protecting jobs.

In addition, Title III of the Act creates a program of special payments to hospitals that serve vulnerable populations. These include hospitals that serve a large number of illegal aliens who do not have a source of insurance and poor individuals who cannot meet coinsurance, cost-sharing, or

deductible obligations. The bulk of these funds will flow to inner-city public hospitals.

Further, the Secretary may designate certain essential community providers with which health plans must contract at fair reimbursement rates for a period of at least five years. Inner-city hospitals are eligible to be included under these provisions.

In addition to these payment streams which should help assure inner-city hospitals do not lose jobs, the President's plan will have the effect of enhancing employment opportunities for health workers. The new long-term care program will require a substantial expansion in the number of home health nurses and aides, and many will be in inner-city neighborhoods. The Act also creates a new National Institute for Health Care Workforce Development jointly between the Departments of Labor and Health and Human Services which would help assess the employment impact of health care reform and gives the Department of Labor new program authorities for upgrading and retraining displaced workers.

ADDENDUM

Three provisions in Title VII of the Health Security Act that also bear on your questions regarding the provision of health care to inner-city populations.

First, hospitals and other nonprofit health care providers will continue to be eligible for tax exemption as charitable organizations. In order to maintain their tax-exempt status, hospitals and other nonprofit providers, in addition to meeting the standards of current law, will be required to assess the health needs of their community and develop a plan to meet those needs. This will help to ensure that an inner-city nonprofit hospital is being responsive to the needs of the residents in its area (Section 7601).

Second, the Act contains tax incentives to encourage providers to practice in underserved areas. A physician who commences work full time in an area that is designated as being short of health professionals and who receives the required certification from HHS will be eligible to receive a nonrefundable tax credit of \$1,000 per month for up to 60 months. Physicians must work in the area for five consecutive years to receive the full credit; they receive a portion of the credit if they work more than two consecutive years in the area. Certified nurse-midwives, nurse practitioners, and physician assistants who work in health professional shortage areas can receive a nonrefundable tax credit of \$500 per month for up to 60 months, subject to the same restrictions as physicians (Section 7801).

Third, physicians who work in areas designated as being short of health professionals may be allowed to expense an additional \$10,000 of medical equipment purchases in a year, in addition to the \$17,000 already permitted under current law.

1 (j) CLINICIAN VISIT.—For purposes of this section,
2 the term “clinician visit” includes the following health pro-
3 fessional services (as defined in section 1112(c)):

4 (1) A complete medical history.

5 (2) An appropriate physical examination.

6 (3) Risk assessment.

7 (4) Targeted health advice and counseling, in-
8 cluding nutrition counseling.

9 (5) The administration of age-appropriate im-
10 munizations and tests specified in subsections (b)
11 through (h).

12 (k) IMMUNIZATIONS AND TESTS NOT ADMINISTERED
13 DURING CLINICIAN VISIT.—Notwithstanding subsection
14 (i)(5), the clinical preventive services described in this sec-
15 tion include an immunization or test described in this sec-
16 tion that is administered to an individual consistent with
17 any periodicity schedule for the immunization or test dur-
18 ing the age range specified for the immunization or test,
19 and any administration fee for such immunization or test,
20 even if the immunization or test is not administered dur-
21 ing a clinician visit.

22 SEC. 1115. MENTAL ILLNESS AND SUBSTANCE ABUSE SERV-
23 ICES.

24 (a) COVERAGE.—The mental illness and substance
25 abuse services that are described in this section are the

1 following items and services for eligible individuals, as de-
2 fined in section 1001(c), who satisfy the eligibility require-
3 ments in subsection (b):

4 (1) Inpatient and residential mental illness and
5 substance abuse treatment (described in subsection
6 (c)).

7 (2) Intensive nonresidential mental illness and
8 substance abuse treatment (described in subsection
9 (d)).

10 (3) Outpatient mental illness and substance
11 abuse treatment (described in subsection (e)), in-
12 cluding case management, screening and assessment,
13 crisis services, and collateral services.

14 (b) **ELIGIBILITY.**—The eligibility requirements re-
15 ferred to in subsection (a) are as follows:

16 (1) INPATIENT, RESIDENTIAL,
17 NONRESIDENTIAL, AND OUTPATIENT TREATMENT.—
18 An eligible individual is eligible to receive coverage
19 for inpatient and residential mental illness and sub-
20 stance abuse treatment, intensive nonresidential
21 mental illness and substance abuse treatment, or
22 outpatient mental illness and substance abuse treat-
23 ment (except case management and collateral serv-
24 ices) if the individual—

1 (A) has, or has had during the 1-year pe-
2 riod preceding the date of such treatment, a
3 diagnosable mental disorder or a diagnosable
4 substance abuse disorder; and

5 (B) is experiencing, or is at significant risk
6 of experiencing, functional impairment in fam-
7 ily, work, school, or community activities.

8 For purposes of this paragraph, an individual who
9 has a diagnosable mental disorder or a diagnosable
10 substance abuse disorder, is receiving treatment for
11 such disorder, but does not satisfy the functional im-
12 pairment criterion in subparagraph (B) shall be
13 treated as satisfying such criterion if the individual
14 would satisfy such criterion without such treatment.

15 (2) CASE MANAGEMENT.—An eligible individual
16 is eligible to receive coverage for case management
17 if—

18 (A) a health professional designated by the
19 health plan in which the individual is enrolled
20 determines that the individual should receive
21 such services; and

22 (B) the individual is eligible to receive cov-
23 erage for, and is receiving, outpatient mental
24 illness and substance abuse treatment with re-

1 spect to a diagnosable mental disorder or a
2 diagnosable substance abuse disorder.

3 (3) SCREENING AND ASSESSMENT AND CRISIS
4 SERVICES.—All eligible individuals enrolled under a
5 health plan are eligible to receive coverage for out-
6 patient mental illness and substance abuse treat-
7 ment consisting of screening and assessment and
8 crisis services.

9 (4) COLLATERAL SERVICES.—An eligible indi-
10 vidual is eligible to receive coverage for outpatient
11 mental illness and substance abuse treatment con-
12 sisting of collateral services if the individual is a
13 family member (described in section 1011(b)) of an
14 individual who is receiving inpatient and residential
15 mental illness and substance abuse treatment, inten-
16 sive nonresidential mental illness and substance
17 abuse treatment, or outpatient mental illness and
18 substance abuse treatment.

19 (c) INPATIENT AND RESIDENTIAL TREATMENT.—

20 (1) DEFINITION.—For purposes of this subtitle,
21 the term “inpatient and residential mental illness
22 and substance abuse treatment” means the items
23 and services described in paragraphs (1) through (3)
24 of section 1861(b) of the Social Security Act when

1 provided with respect to a diagnosable mental dis-
2 order or a diagnosable substance abuse disorder to—

3 (A) an inpatient of a hospital, psychiatric
4 hospital, residential treatment center, residen-
5 tial detoxification center, crisis residential pro-
6 gram, or mental illness residential treatment
7 program; or

8 (B) a resident of a therapeutic family or
9 group treatment home or community residential
10 treatment and recovery center for substance
11 abuse.

12 The National Health Board shall specify those
13 health professional services described in section 1112
14 that shall be treated as inpatient and residential
15 mental illness and substance abuse treatment when
16 provided to such an inpatient or resident.

17 (2) LIMITATIONS.—Coverage for inpatient and
18 residential mental illness and substance abuse treat-
19 ment is subject to the following limitations:

20 (A) RESIDENTIAL MENTAL ILLNESS
21 TREATMENT.—Such treatment, when provided
22 with respect to a diagnosable mental disorder in
23 a setting that is not a hospital or a psychiatric
24 hospital, is covered only to avert the need for,
25 or as an alternative to, treatment in a hospital

51

1 or a psychiatric hospital, as determined by a
2 health professional designated by the health
3 plan in which the individual receiving such
4 treatment is enrolled.

5 (B) RESIDENTIAL SUBSTANCE ABUSE
6 TREATMENT.—Such treatment, when provided
7 with respect to a diagnosable substance abuse
8 disorder in a setting that is not a hospital or
9 a psychiatric hospital, is covered only if a
10 health professional designated by the health
11 plan in which the individual receiving such
12 treatment is enrolled determines (based on cri-
13 teria that the plan may choose to employ) that
14 the individual should receive such treatment.

15 (C) LEAST RESTRICTIVE SETTING.—Such
16 treatment is covered only when—

17 (i) provided to an individual in the
18 least restrictive inpatient or residential set-
19 ting that is effective and appropriate for
20 the individual; and

21 (ii) less restrictive intensive
22 nonresidential or outpatient treatment
23 would be ineffective or inappropriate.

24 (D) ANNUAL LIMIT.—Prior to January 1,
25 2001, such treatment is subject to an aggregate

52

1 annual limit of 30 days. A maximum of 30 ad-
2 ditional days of such treatment shall be covered
3 for an individual if a health professional des-
4 ignated by the health plan in which the individ-
5 ual is enrolled determines in advance that—

6 (i) the individual poses a threat to his
7 or her own life or the life of another indi-
8 vidual; or

9 (ii) the medical condition of the indi-
10 vidual requires inpatient treatment in a
11 hospital or a psychiatric hospital in order
12 to initiate, change, or adjust pharma-
13 cological or somatic therapy.

14 (E) INPATIENT HOSPITAL TREATMENT

15 FOR SUBSTANCE ABUSE.—Such treatment,
16 when provided in a hospital or a psychiatric
17 hospital with respect to a diagnosable substance
18 abuse disorder, is covered under this section
19 only for detoxification requiring the manage-
20 ment of psychiatric conditions associated with
21 withdrawal from alcohol or drugs. The items
22 and services described in this section do not in-
23 clude medical detoxification as required for the
24 management of medical conditions associated

1 with withdrawal from alcohol or drugs (which is
2 covered under section 1111).

3 (d) INTENSIVE NONRESIDENTIAL TREATMENT.—

4 (1) DEFINITION.—For purposes of this subtitle,
5 the term “intensive nonresidential mental illness and
6 substance abuse treatment” means diagnostic or
7 therapeutic items or services provided with respect
8 to a diagnosable mental disorder or a diagnosable
9 substance abuse disorder to an individual—

10 (A) participating in a partial hospitaliza-
11 tion program, a day treatment program, a psy-
12 chiatric rehabilitation program, or an ambula-
13 tory detoxification program; or

14 (B) receiving home-based mental illness
15 services or behavioral aide mental illness serv-
16 ices.

17 The National Health Board shall specify those
18 health professional services described in section 1112
19 that shall be treated as intensive nonresidential men-
20 tal illness and substance abuse treatment when pro-
21 vided to such an individual.

22 (2) LIMITATIONS.—Coverage for intensive
23 nonresidential mental illness and substance abuse
24 treatment is subject to the following limitations:

1 **(A) DISCRETION OF PLAN.**—An individual
2 shall receive coverage for such treatment if a
3 health professional designated by the health
4 plan in which the individual is enrolled deter-
5 mines (based on criteria that the plan may
6 choose to employ) that the individual should re-
7 ceive such treatment.

8 **(B) TREATMENT PURPOSES.**—Such treat-
9 ment is covered only when provided—

10 (i) to avert the need for, or as an al-
11 ternative to, treatment in residential or in-
12 patient settings;

13 (ii) to facilitate the earlier discharge
14 of an individual receiving inpatient or resi-
15 dential care;

16 (iii) to restore the functioning of an
17 individual with a diagnosable mental dis-
18 order or a diagnosable substance abuse
19 disorder; or

20 (iv) to assist such an individual to de-
21 velop the skills and gain access to the sup-
22 port services the individual needs to
23 achieve the maximum level of functioning
24 of the individual within the community.

25 **(C) ANNUAL LIMIT.**—

24 (D) DETOXIFICATION.—Intensive
25 nonresidential mental illness and substance

56

1 abuse treatment consisting of detoxification is
2 covered only if it is provided in the context of
3 a treatment program.

4 (E) OUT-OF-POCKET MAXIMUM.—Prior to
5 January 1, 2001, expenses for intensive
6 nonresidential mental illness and substance
7 abuse treatment that an individual incurs prior
8 to satisfying a deductible applicable to such
9 treatment, and copayments and coinsurance
10 paid by or on behalf of the individual for such
11 treatment, may not be applied toward any an-
12 nual out-of-pocket limit on cost sharing under
13 any cost sharing schedule described in part 3 of
14 this subtitle if such treatment is provided—

15 (i) with respect to a diagnosable sub-
16 stance abuse disorder; or

17 (ii) pursuant to subparagraph (C)(ii).

18 (e) OUTPATIENT TREATMENT.—

19 (1) DEFINITION.—For purposes of this subtitle,
20 the term “outpatient mental illness and substance
21 abuse treatment” means the following services pro-
22 vided with respect to a diagnosable mental disorder
23 or a diagnosable substance abuse disorder in an out-
24 patient setting:

25 (A) Screening and assessment.

57

- 1 (B) Diagnosis.
- 2 (C) Medical management.
- 3 (D) Substance abuse counseling and re-
- 4 lapse prevention.
- 5 (E) Crisis services.
- 6 (F) Somatic treatment services.
- 7 (G) Psychotherapy.
- 8 (H) Case management.
- 9 (I) Collateral services.

10 (2) **LIMITATIONS.**—Coverage for outpatient
11 mental illness and substance abuse treatment is sub-
12 ject to the following limitations:

13 (A) **HEALTH PROFESSIONAL SERVICES.**—
14 Such treatment is covered only when it con-
15 stitutes health professional services (as defined
16 in section 1112(c)(2)).

17 (B) **DISCRETION OF PLAN.**—An individual
18 shall receive coverage for outpatient mental ill-
19 ness and substance abuse treatment consisting
20 of substance abuse counseling and relapse pre-
21 vention if a health professional designated by
22 the health plan in which the individual is en-
23 rolled determines (based on criteria that the
24 plan may choose to employ) that the individual
25 should receive such treatment. This subpara-

1 graph does not apply to group therapy covered
2 pursuant to subparagraph (C)(ii)(II).

3 (C) ANNUAL LIMITS.—

4 (i) PSYCHOTHERAPY AND COLLAT-
5 ERAL SERVICES.—Prior to January 1,
6 2001, psychotherapy and collateral services
7 are subject to an aggregate annual limit of
8 30 visits per individual. Additional visits
9 may be covered, at the discretion of the
10 health plan in which the individual receiv-
11 ing treatment is enrolled, to prevent hos-
12 pitalization or to facilitate earlier hospital
13 release, for which the number of covered
14 days of inpatient and residential mental ill-
15 ness and substance abuse treatment that
16 are available to an individual under the 30-
17 day limit described in the first sentence of
18 subsection (c)(2)(D) shall be reduced by 1
19 day for each 4 visits. After such number
20 has been reduced to zero, no additional vis-
21 its under the preceding sentence may be
22 covered.

23 (ii) SUBSTANCE ABUSE COUNSELING
24 AND RELAPSE PREVENTION.—

59

(I) IN GENERAL.—Except as provided in subclause (II), the number of covered days of inpatient and residential mental illness and substance abuse treatment that are available to an individual under the 30-day limit described in the first sentence of subsection (c)(2)(D) shall be reduced by 1 day for each 4 visits for substance abuse counseling and relapse prevention that are covered for the individual under subparagraph (B). After such number has been reduced to zero, no visits for substance abuse counseling and relapse prevention may be covered, except as provided in subclause (II).

(II) GROUP THERAPY.—Prior to January 1, 2001, substance abuse counseling and relapse prevention consisting of group therapy is subject to a separate aggregate annual limit of 30 visits, if such therapy occurs within 12 months after the individual has received, with respect to a diagnosable

60

1 substance abuse disorder, inpatient
2 and residential mental illness and sub-
3 stance abuse treatment or intensive
4 nonresidential mental illness and sub-
5 stance abuse treatment. The provi-
6 sions of clause (i) and subclause (I)
7 do not apply to therapy that is de-
8 scribed in the preceding sentence.

9 (D) DETOXIFICATION.—Outpatient mental
10 illness and substance abuse treatment consist-
11 ing of detoxification is covered only if it is pro-
12 vided in the context of a treatment program.

13 (E) OUT-OF-POCKET MAXIMUM.—Prior to
14 January 1, 2001, expenses for outpatient men-
15 tal illness and substance abuse treatment that
16 an individual incurs prior to satisfying a de-
17 ductible applicable to such treatment, and
18 copayments and coinsurance paid by or on be-
19 half of the individual for such treatment, may
20 not be applied toward any annual out-of-pocket
21 limit on cost sharing under any cost sharing
22 schedule described in part 3 of this subtitle.

23 (f) OTHER DEFINITIONS.—For purposes of this sub-
24 title:

1 (1) CASE MANAGEMENT.—The term “case management” means services that assist individuals in
2 gaining access to needed medical, social, educational,
3 and other services.

5 (2) DIAGNOSABLE MENTAL DISORDER AND
6 DIAGNOSABLE SUBSTANCE ABUSE DISORDER.—The
7 terms “diagnosable mental disorder” and
8 “diagnosable substance abuse disorder” mean a dis-
9 order that—

10 (A) is listed in the Diagnostic and Statis-
11 tical Manual of Mental Disorders, Third Edition,
12 Revised or a revised version of such man-
13 ual (except V Codes for Conditions Not Attrib-
14 utable to a Mental Disorder That Are a Focus
15 of Attention or Treatment);

16 (B) is the equivalent of a disorder de-
17 scribed in subparagraph (A), but is listed in the
18 International Classification of Diseases, 9th Re-
19 vision, Clinical Modification, Third Edition or a
20 revised version of such text; or

21 (C) is listed in any authoritative text speci-
22 fying diagnostic criteria for mental disorders or
23 substance abuse disorders that is identified by
24 the National Health Board.

1 (3) PSYCHIATRIC HOSPITAL.—The term “psy-
2 chiatric hospital” has the meaning given such term
3 in section 1861(f) of the Social Security Act, except
4 that such term shall include—

5 (A) in the case of an item or service pro-
6 vided to an individual whose applicable health
7 plan is specified pursuant to section 1004(b)(1),
8 a facility of the uniformed services under title
9 10, United States Code, that is engaged in pro-
10 viding services to inpatients that are equivalent
11 to the services provided by a psychiatric hos-
12 pital;

13 (B) in the case of an item or service pro-
14 vided to an individual whose applicable health
15 plan is specified pursuant to section 1004(b)(2),
16 a facility operated by the Department of Veter-
17 ans Affairs that is engaged in providing services
18 to inpatients that are equivalent to the services
19 provided by a psychiatric hospital; and

20 (C) in the case of an item or service pro-
21 vided to an individual whose applicable health
22 plan is specified pursuant to section 1004(b)(3),
23 a facility operated by the Indian Health Service
24 that is engaged in providing services to inpa-

63

1 tients that are equivalent to the services pro-
2 vided by a psychiatric hospital.

3 **SEC. 1116. FAMILY PLANNING SERVICES AND SERVICES
4 FOR PREGNANT WOMEN.**

5 The services described in this section are the follow-
6 ing items and services:

7 (1) Voluntary family planning services.
8 (2) Contraceptive devices that—
9 (A) may only be dispensed upon prescrip-
10 tion; and
11 (B) are subject to approval by the Sec-
12 etary of Health and Human Services under the
13 Federal Food, Drug, and Cosmetic Act.
14 (3) Services for pregnant women.

15 **SEC. 1117. HOSPICE CARE.**

16 The hospice care described in this section is the items
17 and services described in paragraph (1) of section
18 1861(dd) of the Social Security Act, as defined in para-
19 graphs (2), (3), and (4)(A) of such section (with the ex-
20 ception of paragraph (2)(A)(iii)), except that all references
21 to the Secretary of Health and Human Services in such
22 paragraphs shall be treated as references to the National
23 Health Board.

Chairman RANGEL. Let me have Herbert Pardes, Dr. Pardes, who is vice president of Health Sciences and the dean of medicine at Columbia, and Dr. Healton, who would be with him who is the associate dean, School of Public Health, and I would like to say that between Harlem Hospital and Columbia that you made a great contribution toward laying out the problems that we have in central Harlem, and some of the solutions, and I was pleased to hear that Dr. Lee thought that it has gone a long way in trying to assist us in finding some solutions.

Unfortunately, I have said that if there is any kind of a problem that deals with the poor, we have it at Harlem Hospital. We do have an outstanding international university as partners in trying to find some answers to these things. Naturally, this is the first opportunity that we get to show our failure and success record with a great hospital and a great teaching hospital and a great university system, so I hope as you have heard, what we just went through that you might come forward with some ideas as to where we can find the people that may not have the answers, but they know the problem. I just can't see if you brought a guy in with tuberculosis and you cured him at Harlem Hospital with all of the advanced research that you have had at Columbia and then after he is cured you put him out in the snow with no clothes on that you—and that is that.

And with some of these things our biggest problem wasn't having access, you know. We always had the hospital, so why don't you start with your testimony.

As with all of our witnesses, your written testimony will be in the record without objection, and then you can either read it or highlight it or present it any way that you feel comfortable. Thank both of you for being here.

STATEMENTS OF HERBERT PARDES, M.D., VICE PRESIDENT, HEALTH SCIENCES, AND DEAN, FACULTY OF MEDICINE, COLUMBIA UNIVERSITY, NEW YORK, N.Y., AND CHERYL HEALTON, PH.D., ASSOCIATE DEAN, SCHOOL OF PUBLIC HEALTH

Dr. PARDES. Well, thank you very much, Mr. Rangel. I want to emphasize that it is a particular pleasure for us to appear before this committee and particularly before you. We are proud and fortunate to have you as our representative, and your leadership in the area of health, in the area of concern for citizens, in the area of substance abuse and so many other issues is, I think, a model for the Nation.

I am, as you have mentioned, dean and vice president of health sciences at Columbia. I had been in the Government here so I have some sense of Government work, having been Director of NIMH and formerly Assistant Surgeon General, and I am delighted that I have Dr. Cheryl Healton, who is associate dean of the Columbia School of Public Health with me.

I want to emphasize several points. Number one, we applaud many of the goals and intentions of the new Health Reform Act. The notion of having broad benefits, of making sure everybody is covered is from our vantage point an issue that is long overdue. The notion of reducing administration and making the delivery of

health care more humanly manageable for providers is also critical. The notion of a seamless system in which one protects people from being in the danger of having no health insurance and a major crisis is all commendable.

We want to be, however, sensitive to the enormous complexity of the needs of citizens of large cities. Just as you said a moment ago it is not just giving the health care in the hospital, we have to look at the whole web of social and economic forces within which any health care problem arises, and within which health care is delivered, and in addition we want to emphasize a third point here, the critical role of essential providers such as public hospitals and academic health centers.

They have to be sustained in order that we may bring the best of care ultimately, which is what we should do, to all the citizens of this country. We have not had the opportunity to digest fully this very large and complex plan. There are aspects of the plan which we feel should be helpful to our citizens as well as safeguards that need to be considered when a final plan is passed.

I guess we all assume that the plan is here for discussion and how the Congress will ultimately deal with it, the administration, is something we will have to wait and see. Some of our comments are taken from our urban health conference held at the Harlem Hospital Center in June with you, Congressman Rangel, and from a subsequent briefing we held in Washington in October.

Columbia is an academic health center. It has a long-standing affiliation with Harlem Hospital Center which is a distinguished national significant hospital, an affiliation that has assisted in training minority physicians and other physicians in the delivery of care in the urban setting. I would like to particularly make some comments on the overriding problems in inner cities and the health status of inner-city residents which I think are resonant with some of the thrust of your comments.

The most striking indication of health status of any community is its death rate. Between 1985 and 1988, while New York City residents died at the same rate as the U.S. population, individuals in Harlem died at one and one half times that rate. For inner-city residents higher than expected death rates and shortened life expectancies are partly related to drug abuse, to AIDS, to tuberculosis, to homicide, to alcohol. But the high rates of excess mortality from the common killers—heart disease, cancer, stroke—indicate that the health care job is not being done in terms of primary prevention. This is not new.

Drs. Colin McCord and Harold Freeman noted in the *New England Journal of Medicine* in 1990 that a black male growing up in Harlem has less of a chance of reaching age 65 than a male growing up in the Third World country of Bangladesh. This fact and other health problems are also reflected in higher infant mortality rates. Disease and illness are strongly influenced by socioeconomic factors. I think that is a critical precept for any health care change.

Here Harlem is prototypic of underserved urban America. Central Harlem is one of the most impoverished areas in the Nation, and stark poverty is related to and compounded by unemployment, poor housing, homelessness, poor nutrition, crime, vio-

lence, and poor education. Drug abuse is an example of the problem that is central to so many others.

Beyond killing people, drug abuse is directly related to AIDS, TB, child abuse, spouse abuse, premature births, crime and violence. It is a leading cause of death among 25- to 44-year-olds in Harlem, and I might say that my own concern about drug abuse, having worked in this field for a while, caused me to recruit Dr. Herbert Kleber, Dr. Marion Fishman and also to invite Mr. Califano to set up the center at CASA which is designed to try to give some of the authoritative information that you very justifiably want to hear about. But deaths don't tell the whole story about health status. There are much larger numbers of individuals who are afflicted with illnesses, disabled and need care.

These wide ranging problems place burdens on providers of care in the inner cities. We must recognize that this is true for both individual practitioners and institutions. We know that we need more primary care doctors. We also know that we need to support them, to reimburse them, to provide a system in which they can function effectively. The complexities of care place large burdens on inner-city hospitals, both public and private.

The president of the National Association of Public Hospitals has indicated that their 72 members averaged 260,000 emergency room and outpatient visits, and 18,000 admissions in 1990, over 10 times the volume of the average American hospital. In addition, many private hospitals are serving as safety net hospitals and in New York City according to Mr. Raske they provided \$2.5 billion in uncompensated care with losses in the millions of dollars.

Academic health centers are particularly heavily involved, providing care, teaching and research. The 287 members of the hospital part of the AAMC, the American Association of Medical Colleges, absorbed 50 percent of the charity care in this country. For the patients seen at Columbia and Presbyterian Hospital, reimbursement is obtained in the following way: 30 percent by Medicaid, 35 percent by Medicare, 10 percent self-pay.

Academic centers and teaching hospitals such as Harlem Hospital Center provide a tremendous amount of care to the underserved in our Nation. In fact, 120 major teaching hospitals across the Nation provide billions in charity care each year. These hospitals also train our future physicians. These centers are critical and must be maintained in urban settings so that patients can continue to benefit from the cross-fertilization of all the hospitals and the medical schools.

What really should be our goal is to bring the best of care to all the citizens. In examining proposals for change, we also must increase cost-effectiveness, not simply save costs. Technologies which may in the early stages cost us a little more may enable us to identify ways to save costs with new pharmaceutical and other treatment interventions.

In the underserved urban areas, access to care has often borne an inverse relationship to need. The Nation's teaching and public hospitals have long served as a refuge for the poor years before the landmark passage of Medicaid gave the poor entree to the system. The academic health centers continue to have a vital role to play as the government's central medical research partner, as centers

for the demonstration of innovative approaches to health care delivery, as checkers on the community health level, and as direct providers through the proposed health alliances.

We should all bear in mind as we reconfigure our health system that the United States leads the world in medical research advances. Not unlike the role our national defense system plays for many nations of the world, our medical research apparatus has provided and will continue to provide the intellectual foundation for much of the world's health care, so the costs we incur here reap dividends for the entire population of the world.

We must also be aware of the fact that today's high technology or experimental intervention often becomes tomorrow's primary care. For example, our relentless search for a cure for AIDS, and I might say that there have been three or four discoveries at Columbia alone which have added to our understanding of the way the AIDS virus works, but that work moved forward within the context of the delivery of multiple, highly complex treatment interventions for those currently affected, yet when an effective vaccine is discovered, AIDS as we know it may join the ranks of other vaccine-preventable diseases, and that is what we would like to accomplish.

Everybody could then be vaccinated through this low-cost approach. So to improve our primary care system at the expense of medical research would be dangerous and what we have got to do is both improve the primary care system and sustain the best of medicine. I might mention that Bud Relman, one of the distinguished doctors in this country, made, I think, the very apt point that if we don't continue to support academic medicine and biomedical research, the medicine of the 21st century will be the medicine we are practicing in the 20th century.

I would now like to ask my colleague from the school of public health, and we are concerned about the interaction between public health and personal health. I would like to ask my colleague, Dean Healton, to now add some comments.

Ms. HEALTON. Thank you, Congressman Rangel. I note that you are all familiar with the conference that Columbia convened and the press conference that recently occurred in Washington during which our new president at Columbia, George Rupp, pointed out that there are essential ingredients in this health care plan that have been set forth that will be of great help to inner-city residents, but we also would like to take this opportunity to set forth a few brief cautionary areas that we hope the Congress can work on to improve the plan.

First and foremost, universal coverage, the proposed plan provision to provide universal coverage is its most important aspect and one that would clearly benefit inner cities.

The provision of broad benefits you are all familiar with. The package includes a series of broad benefits which clearly would assist all citizens of the country, most particularly inner city.

Outreach and education programs, this component of the plan at the moment really appears currently unfunded and it needs some expansion to appreciate how it will, in fact, work.

Increased emphasis on health promotion and prevention, I will elaborate on that in a moment.

Special programs for special populations, Dr. Lee earlier mentioned the importance of maintaining key categorical programs, Ryan White would be one example. There are many others.

Appropriate increases in primary care providers, a relentless theme, one in which your current Assistant Secretary, Phil Lee, has had significant involvement as chair of PPRC. Clearly there have to be mechanisms to expand the availability of primary care physicians and their appropriate distribution around the country.

On the other hand, it is important in inner city hospitals, Harlem Hospital would be a good example, that we not do that at the expense of access to tertiary services. Dr. Pardes' point that our goal is to upgrade the care of everyone, not bring everyone down to the lowest common denominator has to be maintained in the forefront.

Support for safety net hospitals, particularly public hospitals, continued support for academic health centers, and we are aware of the 1.5 percent surcharge, and that is very positive.

On the other hand, the constant ratcheting down of the teaching adjustment that was installed under the DRG legislation 10 years ago has very negative consequences, and as one who has her own gray hairs, I was around when that legislation passed. I know the deal that was struck, and, in fact, that resident-to-bed ratio was meant as a proxy for the complexity of the type of patient that enters the urban teaching hospitals.

Over time I know that has been forgotten because I am in a number of meetings where it is clear to me that what its actual purpose was has been lost in the fray.

Finally, protect essential community providers. Obviously public hospitals, again the categorical programs.

Now, at this conference a number of questions, some of them provocative, were raised. I just want to briefly review them and hope that they might be used as a template as you would evaluate the final plan as it begins to emerge.

First, health alliances will need to make risk-adjusted payments for those plans that enroll a disproportionate share of high risk patients. It is clear that we have got to be very concerned about whether disadvantaged groups will find effective representation on health alliance boards.

Will inner-city residents be the informed and cost-conscious citizens the plan aims to encourage? How will bureaucratic obstacles be reduced so that they can surmount them? Will inner-city residents be forced into low-cost plans because they can afford no other?

As I read the plan, it indicates that the mean or below is the option for the Medicaid rollover so in fact their plans will be systematically less elegant than those others will have, though I must say they will be better off in many respects than they are today because today they are locked out of access to private physician services.

I paid more for a taxicab from my hotel to this building than New York State pays a physician for a Medicaid visit to a private doctor's office. They pay \$9. If every inner-city resident has a health security card by this time next year, how will their pattern of care differ? What special accommodations will be made to enroll

the urban poor, and I consider this potpourri of plans that are going to be made available? Will it be available in the language of the individual trying to enroll?

What accommodations will be made for the one in five inner-city residents who is illiterate? How will enrollment abuses be prevented? How will we stop alliances from finding ways to systematically avoid the most complex and expensive patient and how will we make certain that they do not withhold care at the expense of that individual in order to reap profits?

What mechanism will be used in the inner-city to protect quality of care? What mechanisms can we develop to provide more than emergency coverage for undocumented aliens?

In a moment, I am going to elaborate on that. I think it is a major problem with the plan. I know it is extraordinarily politically attractive to say that the plan will not "cover illegal aliens," but I want to discuss the reality that in the street that is going to be very hard to implement particularly when we in this country ask our physicians to first, do no harm and take a Hippocratic oath that they will care for people.

How can we be certain that health reform advances basic research on the most pressing problems facing the urban poor, such as substance abuse, AIDS, sickle-cell anemia, tuberculosis? How can we make certain that the health care delivery system accommodates the importance of clinical research and how can we foster investment in the systematic search for efficacious and cost-effective clinical interventions?

Congressman Rangel, I think that drug abuse is one area where this really needs to be done. We have had multiple studies out of the Agency for Health Policy and Health Care Research on every issue imaginable. Let's answer that question. Your comments are very apt. There is not an answer to that question, what works.

I want to spend a moment on the special problems of undocumented aliens in urban areas. The highest concentration of undocumented aliens or otherwise known as illegal aliens are in the major cities of this country, Texas, California, Florida, and New York.

The current plan would provide emergency services only to this population and I ask you, is this really what we are about. Do we expect the health care system to be the gatekeepers where immigration and naturalization has failed. Do we think that it is fiscally viable to deny a working albeit illegally working woman who is pregnant prenatal care and remand her child to a \$1,500-a-day intensive care unit?

Do we want a 3-year-old who arrived in Texas in the trunk of a car to be denied an immunization and be capable of spreading measles, which is what happened with the measles outbreak in Houston a few years ago?

Finally I want to focus on four key issues that come from my public health colleagues with regard to the plan that we have before us. To ensure that health reform does more than just reform the current system of providing illness care, senior public health officials, including Dr. Lee who just spoke, have urged that the following modifications of the proposed health security plan occur.

First, significant representation of public health-oriented individuals on the National Health Board is essential, and I would submit

that if the board has to be expanded beyond seven it is certainly worth doing so, to make certain that policies serve population-wide needs rather than solely and narrowly focusing on the provision of personal health services.

For example, we need to do more than fix the gunshot wounds. We need to end violence in our society. Household guns are in 50 percent of all homes in this country and I speak as a mother of three. My child is not allowed to go on a play date in a house until I ask "do you have a gun," and 50 percent of the time they tell me, "yes," to my amazement, and my child doesn't go there.

We need to do more than offer free vaccinations. We need to address and understand why high rates of underimmunization occur in poverty communities even in the face of free vaccination policies. Vaccinations are free in New York City. Of the children below the age of 5, 50 percent are not fully vaccinated.

We need to do more than tell people to quit smoking. One in four Americans still smoke. It is a drug administered 40 times a day. It is a highly addictive drug. It is not that easy for the one in four left to quit. They need help.

Finally, we have to move beyond simply providing family planning services to our young people to achieving and understanding and addressing the root causes that fuel the tragedy of children having children and the unprecedented rise in sexually transmitted diseases and HIV infection in adolescents.

Second, we must not permit this very important step forward, the availability at long last of universal coverage, to overshadow the critical importance of the neglected public health infrastructure in this country. While expenditures by businesses, individuals and government for personal health services have risen rapidly over the past three decades, expenditures for traditional public health services have fallen or at best been stagnant. This is particularly unfortunate in view of the tragic arrival of the AIDS epidemic and the reemergence of TB.

Ironically this very problem, the existence of a new difficult and often impossible-to-treat TB is itself in large measure the consequence of our failure to invest in vital public health programs. If we continue unabated leaving the public out of the health security plan we will be unable to address these key problems.

Leaders in public health have called upon the administration and Congress to increase its allocation from the low 1 percent of all public health oriented expenditures now to 3 percent. The dividends will be considerable given the potential for prevention services to ward off illnesses and disease and the central importance of community health surveillance in alerting us to community-wide health problems.

Finally, we are calling for putting the word public back into the health care system by finally beginning to evaluate our health care system based on population-based outcomes. Thus if 5 years from now we still rank poorly in comparison to nearly all industrialized nations in infant mortality, violent death, epidemic control, we must ask ourselves have we been well served.

It is crucial that we embrace this standard at the outset and strive to take a truly revolutionary step forward rather than to continue to accept substandard public health outcomes. Obviously this

is the result of multiple sectors of society. We can't lay at the doorstep of the health care system the rather awful public health indicators that exist in the United States with the greatest medical care system in the world.

However, we can learn lessons from other nations that have very well coordinated public health systems and I will say that 10 years has been spent by the Centers for Disease Control, the American Public Health Association, the National Association of County Health Officials in designing a way to plan on a community level to integrate public health goals and objectives with the actual behavior of agencies.

We need summits where we bring together housing, environmental, police in the same room in the interest of health agenda. We have a series of health objectives.

You may have seen a book called "Healthy People Year 2000." It provides a set of specific goals for this Nation in the year 2000. They cannot be met by the health care system alone. They require integrated planning across multiple agencies.

I think it is a wonderful document, but something that has always concerned me about the document is that you may or may not be aware, we have a different year 2000 standard for different ethnic groups and virtually all of the goals set are standard for the year 2000 are standard for black Americans as below our standard for white Americans, and while I think it is clear that we cannot reach an equitable infant mortality rate by the year 2000, I think our goal should be the same.

I always say that in the classroom. We should say in the year 2000 we have gone 30 percent toward our goal. We should not accept different goals for different racial ethnic groups.

Fourth it is critical that we bring public health leadership into the alliances and that we grant local public health authorities some leverage over the alliances so that we do not have the problem that we identify a TB case, but because it is too expensive to follow them, the health alliance does not engage for example in directly observed therapy that would solve that problem.

This testimony presents our concerns about health reform and its impact on the public health, academic health centers and the delivery of care to urban underserved citizens. There are clearly different methods for reforming the health care system. Our concern is to make certain that all people living in the United States of America are covered under health reform and that we merge the public health and care delivery systems in an appropriate fashion.

Thank you.

[The joint prepared statement follows:]

**TESTIMONY OF HERBERT PARDES, M.D., VICE PRESIDENT FOR HEALTH SCIENCES,
AND DEAN, FACULTY OF MEDICINE, COLUMBIA UNIVERSITY, AND CHERYL
HEALTON, PH.D., ASSOCIATE DEAN, SCHOOL OF PUBLIC HEALTH, COLUMBIA
UNIVERSITY**

Congressman Rangel and distinguished members of the House Ways and Means Subcommittee on Select Revenues, I am pleased to appear before you today on behalf of Columbia University to discuss the impact of the administration's health care reform proposal on the residents of the inner city and other distressed neighborhoods. I am currently Vice President for Health Sciences and Dean of the Faculty of Medicine at Columbia University. Dr. Cheryl Heaton, Associate Dean of the Columbia School of Public Health, is testifying with me today.

Our testimony today will focus on the role of the academic health center in the delivery of health care in the urban setting, the impact of the President's proposal on residents of urban underserved areas, and changes in the proposed reform plans that would improve its overall impact on the health of Americans. Clearly, we have not had the opportunity to digest the full 1,400 pages of the Health Security Act. However, there are aspects of the plan which should be helpful to these residents as well as safeguards that need to be considered when a final plan is passed. Some of our comments today are developed from the Urban Health Conference we held at the Harlem Hospital Center in June with Congressman Rangel and from a subsequent briefing we held in Washington, D.C. in October. Columbia is an academic health center that has had a long-standing affiliation with Harlem Hospital Center—an affiliation that has assisted in training minority physicians and other physicians in the delivery of care in the urban setting.

HEALTH REFORM AND THE IMPACT ON INNER-CITY RESIDENTS

Health Status and Compounding Factors

Before commenting specifically on health reform, we would like to comment on the overriding problems in inner cities and the health status of inner city residents. The most striking indication of health status of any community is its death rate. Between 1985-88, while New York City residents died at the same rate as the US population, individuals in Harlem died at one and one half times that rate.

For inner-city residents higher than expected death rates and shortened life expectancies are partly related to drug abuse, AIDS, tuberculosis, homicide and alcohol. But the high rates of excess mortality from the common killers, i.e. heart disease, cancer and stroke indicate that the health-care job is not being done in terms of primary prevention. This is not new. In fact as Drs. Colin McCord and Harold Freeman noted in the *New England Journal of Medicine* (January 18, 1990), "[A] black male growing up in Harlem has less of a chance of reaching age 65 than a male growing up in the Third World country of Bangladesh." This fact and other health problems are also reflected in higher infant mortality rates.

Disease and illness are strongly influenced by socioeconomic factors. Here Harlem is prototypic of underserved urban America. Central Harlem is one of the most impoverished areas in the nation. Stark poverty is related to, and compounded by, unemployment, poor housing, homelessness, poor nutrition, crime, violence and poor education.

Drug abuse is an example of a problem that is central to so many others. Beyond killing people, drug abuse is directly related to AIDS, Tuberculosis, child abuse, spouse abuse, premature births, crime and violence. It is a leading cause of death among 25-44 year olds in Harlem.

But deaths do not tell the whole story about health status. There are much larger numbers of individuals who are afflicted with illnesses, disabled and need care. These wide-ranging problems place burdens on providers of care in the inner cities. We must recognize that there are two kinds of providers: individual practitioners and institutions. There is extensive documentation describing the lack of doctors--particularly primary care doctors--in inner city areas. These statistics underscore the role institutional providers play. This is not surprising, given the impossibly low rate of reimbursement Medicaid provides to physicians, the high debt burdens of medical school graduates, and the very high costs of caring for extraordinarily sick patients.

The Role of Academic Health Centers in the Urban Setting

The complexities of care place large burdens on inner city hospitals, public and private. Mr. Larry Gage, President of NAPH, has indicated that their "72 NAPH member hospitals across the nation averaged 260,000 emergency room and out-patient visits, and 18,000 admissions in 1990. This was over ten times the volume of the average American hospital. In addition to the public hospitals, many private hospitals also serve as safety net hospitals and in New York City, according to Kenneth Raske, they provided 2.5 billion dollars in uncompensated care with losses in the millions of dollars. And many Academic Health Centers are particularly heavily involved providing care, teaching and conducting

research. For the patients seen at Columbia and the Presbyterian Hospital, reimbursement is obtained from the following: 30 % by Medicaid, 35% by Medicare and 10% self-pay. Academic centers and teaching hospitals such as Harlem Hospital Center provide a tremendous amount of care to the underserved in our nation. In fact, 120 major teaching hospitals across the nation provide billions in charity care each year and write off millions in bad debt. These hospitals train our future physicians. These centers are critical and must be maintained in urban settings so that patients can continue to benefit from the cross-fertilization of all the hospitals and the medical schools. In examining proposals for change, we must increase cost-effectiveness, not just save costs. Technologies may in the early stages increase costs, but research helps us to identify ways to save costs with new pharmaceutical and technologies.

In the underserved urban areas, access to care has often borne an inverse relationship to need. The nation's teaching and public hospitals have long served as a refuge for the poor years before the landmark passage of Medicaid gave the poor entree to the system. The academic health centers continue to have a vital role to play as the government's central medical research partner, as centers for the demonstration of innovative approaches to health care delivery, as purveyors of community level health status surveillance, and as direct providers through the proposed health alliances. We should all bear in mind as we reconfigure our health system that we lead the world in medical research advances. Not unlike the role our national defense system plays for many nation's of the world, our medical research apparatus has provided and will continue to provide the intellectual foundation for much of the world's health care. Thus, the costs we incur here reap dividends the world over. We must also be cognizant of the fact that today's high technology or experimental intervention often becomes tomorrow's primary care. For example, our relentless search for a cure for AIDS moves forward within the context of the delivery of multiple, highly complex treatment interventions for those currently affected. Yet, when an effective vaccine is discovered, AIDS as we know it, will join the ranks of other vaccine preventable diseases. Everyone will be vaccinated through this low-cost approach. Thus, to improve our primary care system at the direct expense of medical research will cost more in the long-run and risk our world wide leadership role.

ESSENTIAL INGREDIENTS FOR HEALTH REFORM: HOW DOES THE CURRENT PLAN MEET THESE NEEDS?

On October 13, 1993, Columbia's President George Rupp and Congressman Charles Rangel held a briefing on Capitol Hill to release the results of the Urban Health Conference held in June. Both during that briefing and at the conference, we identified some essential ingredients necessary for health reform to be positive for inner-city residents. Thus, our comments on the plan are framed around these essential ingredients.

- o **Universal Coverage**-The proposed plan's provision of universal coverage is the most urgent and positive aspect of health reform for urban underserved citizens.
- o **Broad Benefits**-The package includes a series of broad benefits which, if effectively advertised and appropriately included in all plans, could assist urban citizens.
- o **Outreach and Educational Programs**-These programs will need to be combined with the actual coverage in order to guarantee "true" access to health care, not just paper coverage.
- o **Increased Emphasis on Health Promotion and Prevention**-The plan currently includes adult preventive care, well-baby and prenatal care, some preventive dental care and encourages other public health initiatives.
- o **Special Programs for special populations**-These programs would include substance abuse treatment, alcoholism, treatment and treatment for mentally retarded and mentally ill. Trauma services, burn units and treatment for the newborn are also needed.

- o **Appropriate Increase of Primary Care Providers**-The plan provides incentives for the increase in primary care physicians. These incentives may encourage provision of care in the urban setting. As an academic health center, Columbia and its affiliate teaching hospitals, including Harlem Hospital Center, would need to make certain that all specialties are also well-covered and that we extend training to the outpatient setting. Methods of recruiting and retaining of physicians in inner cities must include proper incentives and support.
- o **Support for Safety-Net Hospitals**-Continuation of disproportionate share reimbursement until proper reimbursement is in place.
- o **Continued Support for Academic Health Centers**-The plan would impose a 1.5% surcharge on all health plans to support funding pools for graduate medical education and academic health centers. We are supportive of this initiative. The plan's reduction in indirect medical education payments will seriously hamper our efforts. It is an important historical note that this adjustment was originally incorporated into the DRG legislation to compensate for the poorer health status of teaching hospital patients.
- o **Protect Essential Community Providers** such as safety net hospitals, academic health centers and Federally funded categorical programs which do not duplicate other services. Managed competition, if implemented, must have protection for the urban citizens. There must be protection for the essential community providers who may be faced with individuals such as undocumented aliens, or homeless individuals who may have no way to obtain their health security card.

As President of Columbia, George Rupp said at our briefing in D.C., health reform cannot work for the nation unless it works for the urban disadvantaged. We are already paying the price of care through higher costs when individuals seek tertiary, not primary, care and through increased premiums to pay for uncompensated care.

Despite the many positive aspects of the Clinton plan, in order to protect urban citizens, we must raise some additional concerns stated eloquently by our colleague Larry Brown and others:

1. Health alliances will need to make risk-adjusted payments to plans that enroll high-risk patients. These adjustments must be done correctly in order to insure that plans are financially stable, serve the disadvantaged in fact not just on paper, and provide the wide range of services at high quality that are needed.
2. Will disadvantaged groups find fair and effective representation on health alliance boards?
3. Will inner-city residents be the informed and cost-conscious citizens the plan aims to encourage? How will bureaucratic obstacles be reduced so that they can surmount them?
4. Will inner-city residents be forced into low-cost plans because they can afford no other?
5. Will tightly managed care work well for whole segments of inner-city populations?
6. If every inner-city resident has a health security card by this time next year, how different will their patterns of care-seeking and receiving be?
7. What special accommodations (enrollment centers, etc.) will be made to enroll the urban poor?
8. What special efforts will be made to inform people about choices offered?
9. Will there be true incentive to enroll the sickest patients?
10. How will enrollment abuses be prevented (i.e. avoiding very sick, homelessness or mentally-ill patients?)

11. What mechanisms will insure that health alliances are responsive to community needs?
12. What mechanisms will be used in the inner city to protect quality of care?
13. What mechanisms can we develop to provide more than emergency coverage for undocumented aliens?
14. How can we be certain that health reform advances basic research on the most pressing problems facing our urban poor such as AIDS, sickle cell anemia, tuberculosis, and substance abuse?
15. How can we make certain that the health delivery system accommodates the importance of clinical research?
16. How can we foster further investment in the systematic search for efficacious and cost-effective clinical interventions?

THE SPECIAL PROBLEM OF UNDOCUMENTED ALIENS IN URBAN AREAS

One aspect of the proposed plan--to limit undocumented aliens to emergency services only--is penny-wise and pound foolish. Many of these individuals presently receive comprehensive health care through state medicaid programs while others rely on emergency rooms or state charity care pools. The children of many undocumented aliens are born in the U.S. and already eligible for coverage. We agree with President Clinton's statement that slowing universal coverage will slow costs savings. For this population there are both moral and economic reasons to assist with primary and preventive care rather than only emergency care. Do any of us really want to deny a working mother who is an undocumented alien prenatal care and in doing so potentially relegate her child to a costly and medically precarious stay in a \$1500 a day intensive care unit. Are we prepared to deny a three year old who arrived in America in the trunk of a car a measles vaccination.

PUBLIC HEALTH IN HEALTH REFORM

To insure that health reform does more than just reform the current system of providing illness care, senior public health officials have urged that the following modifications of the proposed Health Security Plan occur.

First, significant representation of public health oriented individuals on the National Health Board is essential to make certain that policies serve population-wide needs rather than be solely and narrowly focused on the provision of patient care services. For example, we need to do more than fix the gunshot wounds--we need to address violence in our society; we need to do more than offer free vaccinations;; we need to understand and address why high rates of under immunization occur in poverty communities even in the face of free vaccination policies; we need to do more than simply have a health provider advise a patient to quit smoking--we need to find out how we can assist the one in four Americans who still smoke and take deliberate steps to help them do so; we need to move beyond providing family planning services to our young people to achieving an understanding of and addressing the root causes which fuel the tragedy of children having children and the unprecedented rise in sexually transmitted diseases and AIDS among this vulnerable population.

Second, we must not permit this very important step forward--the availability at long last of universal coverage-- to overshadow the critical importance of the neglected public health infrastructure in this country. While expenditures by businesses, individuals and government for personal health services have risen rapidly over the past three decades, expenditures for traditional public health services have fallen or at best been stagnant. This is particularly unfortunate in view of the tragic arrival of the AIDS epidemic and the reemergence of TB with its new deadly multi-drug resistant strains. This very problem--the existence of a new, difficult, indeed often impossible to treat TB--is itself in large measure the consequence of our failure to invest in vital public health programs. It will continue unabated if health reform leaves the "public" out of the Health Security Plan. At the present juncture, less than one percent of health expenditures support the traditional public health system. Leaders in public health have called upon the Administration and the Congress to increase this allocation to at least three percent. The dividends will be considerable given the potential for prevention services to ward off illness and disease and the central importance of community health surveillance in alerting us to community-wide health threats.

Third, in keeping with the theme of putting the word "public" back into the concept of the health system, we must as a nation insist that our health reform system be judged by population-based outcomes. Thus, if five years from now, we still rank poorly in comparison to nearly all industrialized nations in infant mortality, life expectancy, violent death and epidemic control, we must ask ourselves how well if at all the new system has served us. It is crucial that we embrace this standard at the outset to strive to take a truly revolutionary step forward from a system which accepts substandard public health outcomes to one that uses these outcomes as the central measure of its success.

Obviously, many factors are responsible for our poor showing as a nation and it is unrealistic to place the blame for the state of our nation's health status on the health care system alone. We all know that social circumstances, public policies, (or lack thereof), and personal choices all contribute to our nation's health status—it is precisely this recognition which has shaped the formulation of health policy in nation's with exemplary health outcomes. These nations have enlisted the concerted efforts of multiple sectors of the society—education, law enforcement, social services, media, housing and environmental in an orchestrated set of cohesive policies in the interest of the society's health and social well-being. Can we do the same at this historic juncture? Can we set aside parochial partisan concerns to secure a healthier future for us all? We have the tools available to meet this challenge. For years, leaders in public health, together with the Centers for Disease Control and Prevention, have been developing and testing in areas throughout the nation programs of coordinated, community health priority planning and health status monitoring, which provide effective blueprints for action on a national scale. "Healthy Communities 2000": Model Standards" and "The Assessment Protocol for Excellence in Public Health (APEX)" are two of the most widely used methods for formulating and focusing local attention on health goals and objectives. A health reform program which brings together these crucial community approaches with the health alliances will begin finally to hold us all collectively responsible for the health of our nation.

Fourth, in addition to bringing together the public health and illness systems, it is crucial or the health reform plan to integrate principles of public health into all levels of health delivery through the alliances. While this important goal would be fostered by the foregoing steps, the health security plan must also grant local health authorities the right to require that alliances undertake specific public health measures. While some standards may be mandated by the National Health Board (e.g. vaccinations), others may be determined by local need. The extension of the National Health Service Corps to include formal training in public health would further insure integration of the public health, prevention and illness systems. We cannot continue to have a national health force, or for that matter an American public which is unable to identify the leading causes of death and disability and the factors and behaviors known to sustain them.

SUMMARY

This testimony presents our concerns about health reform and its impact on the public's health, academic health centers, and the delivery of care to urban underserved residents. We have outlined some of the areas of concern in health status, current provision of uncompensated care, and potential areas that must be evaluated for the plan to succeed in urban areas. Clearly, health reform alone will not bring the care to urban citizens. Education, prevention, and attempts at increasing the viability of the work place will also be of benefit. The health security plan must be evaluated against a template that addresses how it improves the health of rural America, urban America, and our whole nation.

There are clearly many different methods of reforming the health care system. Our concern is to make certain that all people living in the United States of America are covered under health reform. You as legislators have a unique opportunity to assure universal health security and provision of cost-effective health care.

HERBERT PARDES, M.D.

Dr. Pardes is currently Vice President for Health Sciences at Columbia University, Dean of the College of Physicians and Surgeons and Chairman of the Department of Psychiatry. In his role as Vice President, he oversees the College of Physicians and Surgeons, the School of Public Health, the School of Nursing and the School of Oral and Dental Surgery. He served as Director of the National Institute of Mental Health during both the Carter and Reagan administrations. Dr. Pardes has an extensive record of national advocacy and interaction with government leadership. He has testified before the Congress on numerous occasions and has served as a Consultant to the Congressional Office of Technology Assessment (OTA), the National Institutes of Health (NIH) and the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). Dr. Pardes is a member of numerous professional organizations and currently serves as chair of the American Psychiatric Association's Council of Research and is a member of the Dean's Administrative Board of the AAMC and a member of the Institute of Medicine. He is a former President of the American Psychiatric Association. He is on the editorial board of a number of journals and has written over 100 articles and chapters on diverse topics in mental health including suicide, mental health policy, the relationship between psychoanalysis and neuroscience, genetics and the teaching of behavioral sciences. During the 1980's, he was one of the primary leaders developing alliances and facilitating growth of citizen groups for advocating increased research on mental illness. Dr. Pardes received his Doctor of Medicine degree from Downstate Medical Center.

Dr. Cheryl Heaton is Associate Dean, Columbia University School of Public Health and a faculty member in the Division of Socio-medical Sciences. She directs numerous service research and training programs at the School including many multi-institutional projects focused on AIDS. She has held senior administrative posts at both Columbia College of P&S and Cornell Medical. She is currently chair of the Schools of Public Health Council on Public Health Practice and is a member of the National Steering Committee for Model Standards and the Assessment for Protocol for Excellence in Public Health, a body focused on ensuring the application of public health objectives at the local level. She has written and spoken widely on health care reimbursement, underserved populations, drug abuse and AIDS.

Chairman RANGEL. Thank you.

Dr. Pardes, you referred to Dr. Freeman's paper that he had written with another physician and indicated that the life expectancy in Harlem was much lower than in Bangladesh, but he related this directly to poverty, didn't he?

Dr. PARDES. He relates it in his general discussions to a number of issues. I think that poverty is a central question. I think also the availability of social programs which help support people and give them opportunities is critical.

My impression of Dr. Freeman's position would be that it is probably multidetermined. Poverty obviously is one of the central issues.

Chairman RANGEL. I gathered from what Dr. Healton was saying that you have a list of illnesses and health problems that you say go far beyond the delivery of health care, but it seems as though are rooted in poverty. Having said that, I thought I heard you say, Dr. Healton—and I can see why you are a Ph.D. instead of an M.D.—that the national leaders are talking about the relationship between the illnesses and the cost of the illnesses and the circumstances that are there.

Who would be these national leaders that you refer to, Dr. Healton?

Ms. HEALTON. Well, in particular the American Public Health Association, a 50,000-member organization composed of people from someone who is a street-level health educator trying to bring people into drug treatment, through the most senior public health officials of the country, members of HHS, deans of schools, people who are the commissioners of health in the 2,000 local districts.

Chairman RANGEL. No one really deals with underlying conditions. Whenever we have a health bill, we get doctors and providers and they don't want to be left out. They want to make certain that the reimbursement and investment justifies them entering into this profession and they want to do the best they can. But I don't hear too many doctors publicly say "I wish we didn't have to deal with this type of an illness because it is very expensive and the more I attempt to cure it the more it is going to reoccur and that somebody ought to be thinking about removing the conditions that cause people to be dependent on drugs or having these babies and the mother being addicted."

I don't see any of that in the Clinton plan. We are talking about prevention and access, but I want to know, do you have a list of people that are saying that one of the things that you can do for a homeless person after you cure him or her is perhaps take him out of the street, that that might be one of the possible cures? Who is doing that type of thing?

Dr. PARDES. I feel that people in the mental health community have known and argued forever that one cannot simply look at the drug or the clinical intervention as the whole story. When I was at NIMH, one of the things we tried to push for was attention to social needs to assure people housing—

Chairman RANGEL. Who is doing that now?

Dr. PARDES. In the mental health community, there are a number of people who argue that as vigorously as possible. At Columbia we have a program working with people in the armory trying to

help them not only in terms of treatments, but also trying to help them to get rehabilitated into some kind of work or housing situation.

I share your view however that the government should be taking the lead in trying to make this as fully available as possible.

Chairman RANGEL. It seems to me that if we are trying to reduce the cost of health care through prevention and to make certain everyone has access in order to have a stronger and more productive America, somewhere someone has to look at where the costs have been hemorrhaging. It has been in areas of high poverty, high unemployment, high teenage pregnancy, high addiction to alcohol, high crime, and we would go in and say "We are going to try to get you well, but more importantly we are going to try to get you out of this system," because now I think it would be easy to say anyone born into this system, the percentages are their children will be born into this system.

This continues to be a hemorrhage. So while we are trying to stop the hemorrhage, the best way to save costs is to prevent people from getting into this system in the first place.

I am trying to find out since you have to be more than an African-American Member of Congress to talk about your own district, you have to talk about reduction deficits, productivity, competition, NAFTA, the ability of communities to be independent and not dependent on government. I am talking economist type of talk.

Dr. Heaton came closer to identifying the problems because if you are a surgeon, you want to cut on people who need surgery and if you are a doctor you want to treat the sick, and I don't think that is a very high priority, nor do I believe that is their business to stop illnesses, but somebody should be concerned with that.

Dr. PARDES. I would say that the physicians of this country should be increasingly sensitive not simply to the delivery of the medical intervention, but to the fuller context in which citizens have their health care delivered and their health care problems attended to.

In our curriculum, we have introduced a much greater attention to social aspects of medical care for precisely that purpose.

Chairman RANGEL. You know anything I say about doctors, I am not talking about you. You would know that, and I am not talking about Columbia. I am saying I have been here for close to a quarter of a century and I can't remember a doctor not talking about reimbursement, which I am not saying he or she should not.

In this health plan, I don't see—it says if you get in a high risk pool, we will take care of you, but where does it say that my kids don't have to be in this high risk pool? So if I get shot, I get repaired.

What is causing me to get shot? What is causing these kids to have babies? What is causing these things and who?

I am not asking for solutions. Who among the people that you frequent that obviously don't come to Congress and say "We have to do something in order to have a healthy America"—who are these people?

I know I can go to San Francisco and find out who is trying to do something about the curing of it, but who are the people that are saying what you are doing is great and should have been done

a long time ago, but let me tell you how much of that cost of health care is attributed to you not doing something else initially and who would those people be?

As long as you give me fuller coverage, I am going to give you more patients. So it won't be a question of how much money I am getting from the Federal Government. It is a question of whether the money is spent with any degree of priority to protect society from some of the costly expenses. We need to get involved—if I had to pick one thing it would be education.

They walk away, they can protect themselves, even if they make a mistake. If they know how to hold on to a job when they are well, when you cure them, they get a job. I would think that Columbia, more than the School of Medicine, would be able to identify—maybe it is Califano's group, I don't know, but down here every committee tries to find out how much money it can get for the jurisdiction of their committee. So they fight for it.

If it wasn't for Hillary Clinton, we would not be dealing with this subject matter now.

Dr. PARDES. I think the thrust of the comments Dr. Healton made were that the School of Public Health at Columbia recognizes that many health care problems are made all the worse or even originate in a variety of social conditions. I think that was the thrust of what she was trying to say.

Chairman RANGEL. I understood her. I am asking where can I get some help for people? I am so glad that you brought her with you. I don't want to take this time. I would want Dr. Healton to send me a note or refer me to something that has been written so that as we take care of the President's health package somebody else might be dealing with the problem to reduce the need for so many health dollars to be spent.

Dr. Freeman is a cancer specialist and I get the impression that he was not talking about the cure for cancer. He was talking about the relationship between poverty and cancer.

Dr. PARDES. Right.

Chairman RANGEL. So I know that is not a doctor's responsibility, especially if you are getting paid to cure cancer, but someone has to say this makes a lot of sense. Everyone is saying he makes a lot of sense. So what?

Dr. PARDES. We have tried to set up a number of prevention programs which go well beyond either doing surgery or giving a drug. We are trying to set up increasing centers on various problem areas trying to attack aspects of this problem that don't necessarily relate to health care itself.

Chairman RANGEL. I am not making criticism of what Columbia is doing or not doing. I am talking about our nation. It would seem to me that if we wanted to invest in a developing country in order to get a return for the investment and the only issue we were dealing with was health care, and meanwhile people were getting shot, getting drunk and were sleeping in the jungles and were not getting an education, we are not going to invest in that community until they clean up their act.

Obviously what Dr. Healton is talking about is not community prevention, but a national policy that says that if we are going to have a competitive America, we have to be healthy and not have

a propensity to end up in jails and emergency wards. I am leaving the medical people alone and asking you to send to me—you teach at Columbia?

Ms. HEALTON. Yes.

Chairman RANGEL. You can send me what you tell those people to read in order to get a better handle of a broader responsibility than just curing the sick.

Ms. HEALTON. I would just add that we are going to have a structure for report cards for the alliances that are basically consumer ratings of the outcomes of the alliances and ways of monitoring the quality of care provided in the alliances. I think it would be a travesty if we do not find a way—it is not costly to find a way to do this—to have a community health profile report card that every doctor practicing in that alliance has to digest.

If you were to walk up to 10 American people on the street and 10 physicians and ask them the top leading causes of death and the major factors that lead to those causes of deaths, many would be unable to answer you. That is why I am making the point that public health has to be integrated. So I think a public health report card for a community would be a nice adjunct to the health alliance report card so that we can keep our eye on the ball.

Chairman RANGEL. Send me some additional materials because it is clear that the American Medical Association hasn't addressed this and it may be outside the jurisdiction of this committee, but it certainly is related and something we should be talking about.

Mr. Hancock.

Mr. HANCOCK. Thank you, Mr. Chairman.

Dr. Pardes, was your organization or you invited to participate in Mrs. Clinton's Health Care Task Force that ended up promulgating the proposal that the President announced?

Dr. PARDES. We were not invited in at the outset, but somewhere in the spring, Mr. Magaziner called a group of deans in and we have had a few conversations with him since then.

Mr. HANCOCK. But you did not actively participate in the discussions and debates?

Dr. PARDES. No.

Mr. HANCOCK. Dr. Healton, these questions that you have here are very interesting. Shouldn't these questions have been answered by that Health Care Task Force rather than coming here and asking these questions to Members of Congress?

I would think that after 244 days and I don't know how many million dollars, that these questions should have been answered before they came up with a proposal; would you agree with that?

Ms. HEALTON. I think that it would be safe to say that most of those questions were considered by that group. We haven't had a chance to digest all 1,400 pages ourselves, but from our perspective being in an inner-city community, we see that as we always say, the devil is in the details, that there may be serious problems in implementation among inner-city, hard-core poverty populations.

Mr. HANCOCK. Have you submitted this list of questions to whoever was in charge of the task force and asked them to specifically point out where they are answered in the bill? Since there are only 16 of them, it shouldn't take over 150 bureaucrats to answer your questions.

Chairman RANGEL. If the gentleman would yield, I would be glad to join with you and take those questions and send them to the administration to ask for answers.

Mr. HANCOCK. Thank you very much, Mr. Chairman. I think that would be the proper approach.

Chairman RANGEL. Dr. Edelman, of course, is returning. We have an usual hearing that we had the government testify, they were supposed to listen and his representative is here and any questions that can be answered, they will be included in the hearing with possible responses. So we will pursue that.

We have a problem here, members. In 5 minutes we are marking up the North American Free-Trade Agreement here, so our sub-committee is going to have to suspend until 1:30 when we would return to this room. However, for those who have questions for Dr. Healton and Dr. Pardes, they have agreed that if you send them in writing, that they would respond.

You made an outstanding contribution. You make me proud to represent not only Harlem Hospital, but Columbia. We have a lot of work to do and I don't know the true relationship with the Califano team, but based on Dr. Healton's observation and the research being done by Joe Califano, I think we can make a better contribution to this bill before we conclude our legislative work on it.

So thank you very much for what you have done.

Dr. PARDES. Thank you very much, Mr. Rangel.

Mr. JACOBS [presiding]. We will continue the hearings of the Committee on Select Revenue. I think we will have our next panel, Cabrini Medical Center New York, N.Y., Jeffrey Frerichs; Mount Sinai Medical Center, Mr. Greenspan; the Jewish Memorial Hospital, Stanley Fertel; Mary Imogene Bassett Hospital, Dr. William Streck; Hospital Association of New York State, Stephen Cooper.

Gentlemen, if you will proceed in the order in which you are listed. You all know the rules of the New York State Athletic Commission, 5 minutes each, and go to a neutral corner in the case of a knockdown. Break clean at all times.

STATEMENT OF JEFFREY FRERICHS, PRESIDENT, CABRINI MEDICAL CENTER, NEW YORK, N.Y.

Mr. FRERICHS. Thank you very much. My name is Jeff Frerichs from Cabrini in New York. I will not read my entire statement, and I will try to be brief. I and some of my colleagues from New York are here not to object to any of the basic principles and objectives of the health security plan, but to raise serious concerns about some of the means that have been identified, especially those with respect to the financing of the plan as provided in the bill.

Specifically we are extremely concerned, to put it in an understated way, about the extraordinarily high extraction of Medicare and Medicaid revenue from existing providers to help finance health security. Such revenue extraction would, for New York, be not only damaging but could be something from which the hospital system and the health care system could not recover. It should be kept in mind that hospitals are not just acute care inpatient units or facilities.

For example, Cabrini Medical Center is a hospice through which terminally ill patients receive both inpatient and home care. Cabrini also is a certified home health agency. Cabrini is a long-term home health care program. Cabrini is a senior citizen lunch program, and it is also a store-front health information center that attempts to expand and increase health care education in the community.

Cabrini is also a provider of care to patients with HIV disease. Each day we have 85 to 90 patients in the hospital with HIV infection and related disease. Of our HIV patients, 37 percent have a history of drug abuse and 8 to 10 percent are homeless. We are very concerned that under the health alliance structure that the ability with the cost caps to continue to provide the necessary and appropriate level of care to this population will be compromised.

The type of patient that we serve may be good to just exemplify. We have John Doe, for example, who is HIV positive and an IV drug abuser. John Doe reflects the enormous resistance on the part of certain patients to participating in a structured system despite the obvious advantages.

This patient first visited the hospital emergency room in April 1991. Although he was instructed to seek care in the outpatient department, John Doe did not seek such care. Between February and September this patient returned to the hospital ER 23 times. On these occasions the patient was admitted for inpatient care. However, on each of these occasions he would leave against medical advice, only to return later that day to be readmitted.

During the 7-month period John Doe would at times seek the resource intensive care, the ER 2 and 3 days in a row. Although this patient had Medicaid, and he was encouraged and booked for outpatient care, he would only come to the emergency room, and he would stay in the hospital only as long as he felt was necessary. Providers need to be protected by this type of tendency on the part of certain patients, and we ask that the health security plan understand that these realities exist in the marketplace.

We are in New York a system that has provided safety net coverage in a way that could be a model, though it is not a perfect one. We have relied on graduate medical education, and the support for graduate medical education as a way of expanding and ensuring access for the Medicaid population and the uninsured poor. The attempt to extract GME revenue from our hospitals would be counter to the national objectives of expanding access and would be a cruel irony that in a city where access has been expanded to the most needy population that in that city its providers will be penalized the most for doing all of the right things.

We are a capital-starved system, and the attempt to reduce capital payments to hospitals under the proposed financing mechanisms would be severely damaging. That is not just our conclusion, that is the conclusion of a study contracted by the Hospital Association of New York State done by Ohio State University, and the conclusion was that many New York State hospitals will face severe financial problems with the possibility of significant increases in closure and bankruptcy.

It is also very likely that the physical and technological condition of hospital plant facilities will deteriorate in New York State, mak-

ing many New York State hospitals substandard providers of care. It is simply unacceptable for the Medicare and Medicaid cuts enunciated in the plan, announced by the administration to be implemented as part of the legislative package, and I and my colleagues are here to urge that those cuts not be implemented. Thank you very much, Mr. Chairman.

[The prepared statement follows:]

**TESTIMONY OF JEFFREY FRERICHS
CABRINI MEDICAL CENTER, MANHATTAN, NEW YORK**

For more than a century, Cabrini Medical Center has delivered to the Lower East Side of Manhattan what federal health care reform now promises to the nation -- a wide range of easily accessible, community-based primary and acute care services to area residents regardless of their income or insurance status. While we applaud the principles behind the federal effort, we are concerned that unless health care reform is structured with sensitivity, it will hinder rather than help us continue meeting our patients' needs over the next century.

Cabrini, like most hospitals in New York State today, is more than a building in which acute care and emergency care is provided. Yes, we have 493 acute care beds and an emergency department which oversees operation of a paramedic ambulance service as well as a comprehensive emergency services facility.

But we also are a center for all levels of health care. In addition to our outpatient department, which provides a full range of primary medical care, subspecialty care, mental health and alcoholism treatment services to residents of lower Manhattan regardless of their insurance or income status, Cabrini Medical Center also encompasses:

- a hospice through which terminally ill patients may obtain both inpatient and home-based care;
- a certified home health agency;
- a long-term home health care program;
- a senior citizen lunch program; and
- a storefront health information center that offers free lectures, screenings and health literature to the community.

In addition, Cabrini Medical Center has a long tradition of caring for patients with AIDS. The first cases of AIDS were diagnosed at Cabrini in 1981, and in November 1989 Cabrini became a State-Designated AIDS Center. Each day, an average of 85 to 90 HIV-infected patients receive inpatient care at Cabrini. This number represents approximately 20 percent of our general medical/surgical beds. In 1993, Cabrini's acute and primary care service units rendered 31,700 days of care to patients with HIV-related disease.

Of our HIV patients, 37% have a history of drug abuse and 8% to 10% are homeless. As noted in a recent Health Systems Agency publication, "The HIV epidemic is the engine driving much of the TB resurgence in New York City." Between 43% and 56% of all TB patients are HIV positive, although some hospitals report rates of up to 75%. Further, 21% of patients with confirmed TB are homeless. Recent surveys indicate that in the New York metropolitan area nearly 900 beds are occupied by patients with known or suspected Tuberculosis. While the cure of Tuberculosis can be achieved in six months, a longer period of treatment is required for the HIV positive patient. Drug resistant TB can take up to two years to cure.

Despite the promises of universal health insurance, we fear that many of our patients will be left out. How, for example, do you get a health security card to a homeless person? How do you ensure that a drug-clouded person appropriately exercises his or her right to health care? How do you even get a drug-addicted woman to enroll in managed care for pre-natal services, let alone guarantee that she follows her doctor's orders? The case of John Doe, an HIV positive intravenous drug user, reflects the enormous resistance on the part of certain patients to participating in a structured system, despite the obvious advantages. The patient first visited the Cabrini Emergency Room in April, 1991. Although the patient was instructed to visit the outpatient department for follow-up care, John Doe did not seek care at Cabrini until February of 1993. Between February and September the patient returned to the hospital emergency room twenty-three times. On three occasions the patient was admitted for inpatient care. However, on each of these occasions the patient would leave against medical advice, only to return later that day to be readmitted. During this seven month period, John Doe would at times seek the resource intensive care of the Cabrini emergency room two and three days in a row. Although the hospital secured Medicaid entitlements for the patient, and encouraged his follow-up outpatient care, John Doe sought only emergency care and, if admitted, stayed only as long as he felt was necessary. Health care reform will unlikely have little, if any, effect on John Doe and the countless individuals like him.

We need universal health insurance which covers a full range of preventive, primary, acute,

chronic, and continuing care services. But we also need more; we need a system that recognizes that hospitals have been -- and will be -- the safety net for their communities and that these hospitals must be given the financial resources, both from insurance payments and other sources, to meet their needs.

This nation will never provide the universal care that our people need if the government continues to cut spending on medical residents and the physicians who train them. They are the only doctors who will work in inner city neighborhoods; they are the only doctors who will treat Medicaid patients, the homeless, and patients with AIDS. Before it is assumed that interns and residents can be eliminated without adverse effect on access to medical care by inner city residents, it should be recognized that access to care in New York City has been accomplished because of the presence of housestaff and faculty in the teaching hospitals. As a means of providing care to the poor and the Medicaid population, graduate medical education programs are among the most cost effective way of ensuring and expanding access to care. If access to physician care can be guaranteed to this patient population through health care reform, our concerns will be addressed. However, it is not apparent that this is the case at the present time.

Likewise, we will never be able to deliver on the promise of universal health care if the federal government continues to cut allocations for capital. Earlier this year, the Hospital Association of New York State released a study done by Ohio State University professor and researcher William O. Cleverley regarding the financial condition of New York's hospitals. Dr. Cleverley found that our hospitals are starved for capital and lack the reserves necessary to keep up with the state-of-the-art in medical care. Dr. Cleverley concluded, "Many New York State hospitals will face severe financial problems with the possibility of significant increases in closure and bankruptcy. It is also very likely that the physical and technological condition of hospital plant facilities will deteriorate in New York State making many New York State hospitals substandard providers of health care services relative to U.S. hospital standards."

This is why the Hospital Association of New York State and the American Hospital Association are so vehemently opposed to the Medicare and Medicaid cuts proposed in President Clinton's Health Security Act and in alternate health plans.

If you look closely at the Clinton plan, for example, you see that it would cut \$189 billion from Medicare and Medicaid even before all Americans receive their guaranteed health benefits package. In other words, the President proposes to take money from Peter long before he pays part of it to Paul. This is unacceptable.

Equally unacceptable is the misguided notion that once universal health insurance is provided, all bad debt and charity care will be magically eliminated, as will the rationale for non-profit hospitals' tax-exempt status.

To put it bluntly: Universal health insurance is an oxymoron. There simply is no way to guarantee that every American will carry a health insurance card and there is no way to guarantee that Americans who carry insurance cards can and will pay co-payments and deductibles.

Consequently, hospitals and health care centers such as Cabrini will continue to provide charity care. In 1992, Cabrini provided more than \$8 million in free care. While we expect that health reform will reduce that, we know it will not eliminate it. The Subcommittee on Select Revenue Measures is to be commended for considering development of new standards for tax exemption for health care providers. In this regard, we would urge you to look at New York's Community Service Plan process as a model.

Since 1991, the voluntary hospitals in New York have annually published Community Service Plans which detail the health care needs of their communities and how the hospitals plan to or are meeting those needs.

At Cabrini, the process of assessing community needs is simple: We review the statistics that profile the health status of our community, we observe trends within our own in and outpatient populations, and we ask area residents what they need. We developed our AIDS treatment program in response to the growing incidence of AIDS as a leading cause of death in our

community. Because the rates of cancer deaths in our community exceed both Manhattan and New York City averages, we have developed a continuum of oncology services, including cancer detection and early treatment services, comprehensive inpatient care, and the medical and supportive services available through the Cabrini Hospice. We offer a hot, nutritious lunch to senior citizens five days a week because we know that a balanced diet is important to maintaining the health of our growing elderly population. And to enable frail, isolated, homebound elderly to continue living independently, we provide free supportive services to over 400 community seniors through our Outreach to the Elderly Program.

Cabrini is not unique in this regard. All across New York, hospitals are providing their communities with services that are too often overlooked. There is a hospital in western New York which provides motorized transportation to health care for its largely Amish population. There is a hospital in the Southern Tier which routinely launders the clothing of indigent individuals who seek treatment in their emergency room. There are hospitals all over New York which literally bring health care to individuals' homes and community centers via vans with lead screening equipment, breast cancer testing equipment, and childhood immunization serums.

These services are true community services that go way beyond the traditional definition of charity care. They must continue and must be financed in whatever health reform plan emerges.

In summary and against this backdrop, Cabrini and the Hospital Association of New York State recommend that any health reform plan, at a minimum, contain:

- Universal health insurance which provides a comprehensive package of preventive, primary, acute, chronic, and continuing health care services, including mental health and substance abuse rehabilitation services.
- Equal coverage for all Americans; in other words, Medicare as well as Medicaid should be folded into national health insurance.
- An emphasis on community-based health planning.
- Recognition of the important role that academic medical centers play in providing care to inner city and disadvantaged communities.
- An adequate level of capital investment.
- Special funding to comply with federal guidelines for infection control related to AIDS and TB.
- Shared responsibility among employers, citizens, and government for adequately financing promised health care services.
- Public accountability for the clinical effectiveness and economic efficiency of health plans.
- Antitrust reforms which will foster collaboration among health care providers.
- Medical liability reforms.

These are the criteria by which hospitals in New York will evaluate the various health reform plans which emerge in Washington.

As a non-profit medical center -- and one which reflects the religious principles and humane values of its foundress St. Frances Xavier Cabrini -- Cabrini Medical Center has as its mission community service. Within our hospital mission statement you will find the following commitment: "We pledge to remain aware of the changing needs of those we serve and to commit both human and financial resources to future efforts which continue our Cabrianian tradition of service, compassion, and excellence." What we ask of our government is that it provide an environment in which we can do just that.

Mr. JACOBS. Mr. Frerichs, you were right in everything you said except one thing, you wouldn't use all your time. You used more than all your time.

Mr. Greenspan.

STATEMENT OF BENN GREENSPAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, MOUNT SINAI HEALTH SYSTEM, CHICAGO, ILL.

Mr. GREENSPAN. Thank you, Mr. Jacobs. Good afternoon, I am Benn Greenspan, president and CEO of the Mount Sinai Medical Center not in New York, in Chicago. I want to thank you and the other members of the committee for the opportunity to testify today on the impact of health reform proposals on the health status of low-income and underserved communities.

In my testimony I want to cover three areas. First, I will identify some of the conditions that affect the delivery of health care in communities such as ours with particular emphasis on the examples of substance abuse and violence.

Second, I will discuss some of the roles these issues should play as we consider health reform and any expectation we have that it will actually improve health status and outcomes for our communities.

Finally, I would like to make some recommendations on specific points. The Mount Sinai health system is a network primarily serving the west and south sides of Chicago, including some of the poorest communities in Illinois and arguably among the poorest in the Nation. Our not-for-profit system includes an acute hospital, a freestanding rehab hospital, the Schwab Rehabilitation Hospital, 18 community-based primary care sites, five satellite ambulatory rehab sites, an extensive array of community health and community mental health services and home health care covering most of the city.

The system and its medical center is a 469-bed teaching hospital that provides primary, secondary, tertiary care and is one of the major providers of care to low-income patients in the State of Illinois. We are also a level one trauma center, the highest level certified in Illinois and a level three perinatal center, again the highest level certified in the State.

We provide care to high risk infants, directly and through our community health foundation. Mount Sinai is one of the largest providers of community health care programs in the United States. The west and south side neighborhoods that we serve are a microcosm of this Nation's urban and social health care problems. The areas are predominantly African-American and Latino, with a poverty rate ranging from 38 to 53 percent around us.

Infant mortality rates run 20 to 24 deaths per 1,000 live births in our community, double the national average. Rates for adolescent pregnancies, low birthweight infants and births to single mothers are all extremely high. Health status in general is very poor in these communities. Death rates for virtually every major cause of mortality are nearly double those of the rest of the State and the Nation.

Our commitment to finding solutions to these problems has been shared only by a handful of institutions in the Nation, and out of

our common concern many of us have come together as the National Association of Urban Critical Access Hospitals, and I have provided material to the committee members about the association.

You will hear more about us. There are a myriad of factors that we see that affect health status and the ability of a system to be effective in addressing health status. These factors include poverty, crime, inadequate housing, lack of education and many others.

What I would like to focus on today are just two factors—substance abuse and violence—and to discuss the impact that they have on the health status of our community and on the development of a nationally reformed system of health care.

The community served by Mount Sinai I will recognize having a significant incidence of alcohol and substance abuse. There is virtually no service that Mount Sinai offers that is not in some significant way affected by the issue. Let me begin with maternal and infant health care.

Mount Sinai is a major provider of maternity services to Chicago and a level three perinatal center. As such, we provide a significant amount of care to high risk mothers and infants. Approximately 30 percent of all the babies born at our hospital show evidence of maternal substance abuse.

Analysis of the data on our own patients, along with other studies, has demonstrated to us that use of prenatal care alone does not have a significant impact on maternal substance abuse, nor does it significantly improve those patients' maternal outcomes. A large scale, long-term study in Massachusetts recently published in JAMA also showed that providing coverage for prenatal care in general failed to make any significant improvement in the use of such care and therefore in outcomes.

It is clear to all of us that potent adverse social forces must be addressed directly in order to be overcome, so we have committed our institution to offering programs that are outside the normal range of those services available to most maternity patients. Chicago, like most cities, for example, has an extreme shortage of substance abuse treatment slots for low-income, pregnant and parenting women.

In the past when we identified a woman who was not only in need of treatment but actively seeking it, we couldn't find a slot to treat her. Mount Sinai had to start its own programs. Fresh Start combines therapy, parenting education, day care, case management, and intensive home care and we now have parents who do succeed in beating their addictions and taking care of their families. It is also critical to note that having a substance abuse problem greatly diminishes the likelihood that a patient will seek prenatal care, even if she has access to it.

As an example, Mount Sinai doesn't turn away patients without insurance and has an extensive primary care network. Nonetheless, a significant percentage of our maternity patients present in our ER without prior prenatal care or seek care very late in the pregnancies. On one recent study we found that pregnant women using drugs are seven times less likely to seek prenatal care than women who do not use drugs. It is of great concern to us. Therefore we offer a number of outreach and case management services.

In order to effectively treat the ongoing development problems associated with high risk births, Sinai and Schwab have jointly run a comprehensive, early intervention program for high risk children from birth to age 3. Every single child currently enrolled in the program's problems are related to maternal substance abuse.

Maternity is not the only area in which we encounter the problem. There is a level one trauma center, we have over 2,000 level one traumas each year. It has become clear to us that alcohol and drug abuse play a major role. Of the 1,094 level one traumas in the first 7 months of this year, 656 showed evidence of alcohol use.

While Mr. Califano's study earlier today spoken of noted that more than 20 percent of the Medicaid costs are probably attributable to substance and tobacco abuse, our experience anecdotally shows that 80 percent of the medical admissions under the age of 50 coming through our emergency room have chemical dependency-related illnesses, an enormous cost, Mr. Jacobs.

We have now reached the point additionally where gunshot has become a major cause of spinal cord injury. This is not like the rest of the United States and is not amicable to a national health solution standardized for the country. I present this picture to call attention to the fact that the problems of the underserved are complicated, multifaceted and difficult to address.

Finally, I would like to present just three principles. The first principle is that coverage for care is not the same as access to care. As we can see with many of our patients, other barriers exist besides coverage. Gang territory lines can be as significant a barrier as a brick wall. Fear can be as significant a barrier as mileage. Lack of security can stop more providers from being available than lack of coverage. I would like to make a second principal point.

Prenatal care alone has no significant impact if the use of care is not carried forth. Therefore, a broad range of services is necessary to effect use of care. The third principle is that even with health care coverage many of the patients in our communities we must actively seek will not be sought after by mainstream health providers. They continue to be perceived as undesirable patients and may not receive the range of services they need from all providers. Differential payment is only one factor.

Variation of benefits is only one factor. The underlying social conditions of our community cause many of our patients to have problems that most providers don't want to deal with and they are not committed to addressing it. Three quick solutions and I am done, Mr. Chairman.

First, the implication is that health reform as it affects our inner city and disadvantaged communities, must acknowledge that even universal health care coverage will not guarantee access to care. In order to improve health care status we must support the additional services that are needed to actively engage patients in the system of care.

It is not only an ethical issue, it is a matter of national self-interest. Second, the cost of care in underserved communities is greater than elsewhere. We must recognize the need to support the institutions that have demonstrated the creativity, the expertise, and the commitment to providing that service.

Third, and finally, the concept of essential community providers must be encouraged. This means public and private, critical access providers, primary care and the referral services that support primary care. There is no reason to believe that coverage will automatically make all patients equally desirable to the mainstream health care providers or that all providers will be committed to the complex range of care and services necessary to serve these patients.

We must encourage the quality providers who engage underserved communities to continue to do so. I would like to thank the committee for this opportunity to discuss health care needs for underserved communities.

[The prepared statement and attachment follow:]

**TESTIMONY OF BENN GREENSPAN
THE MOUNT SINAI HEALTH SYSTEM, CHICAGO, ILLINOIS**

Good Morning. I am Benn Greenspan, President and Chief Executive Officer of the Mount Sinai Health System, in Chicago.

I would like to thank Chairman Rangel for the opportunity to testify today about the impact of health reform proposals on the health status of low income and underserved communities. In my testimony, I will cover three areas. First, I will identify some of the conditions that affect the health status and therefore the delivery of health care in communities such as ours, with particular emphasis on the impact of substance abuse and violence. Second, I will discuss the role these issues should play as we consider health reform and any expectation we have that it will improve health status and outcomes for our communities. Finally, I would like to make some recommendations on specific points of the health care reform proposals before Congress.

The Mount Sinai Health System is a network primarily serving the West and South Sides of Chicago, including some of the poorest communities in Illinois, and arguably among the poorest in the nation. Our not for profit System includes Mount Sinai Hospital Medical Center, a large inner city general acute care teaching hospital, the Schwab Rehabilitation Hospital and Care Network, eighteen affiliated community based primary care sites (including thirteen federally qualified health centers), five satellite ambulatory rehabilitation clinics, an extensive array of community mental health services, and home health care services covering most of Chicago.

Mount Sinai Hospital Medical Center, the acute care hospital within the system, is a 469 bed teaching hospital that provides primary, secondary, and tertiary care. Mount Sinai today is one of the major providers of care to low income patients in the state of Illinois. Only 5% of our patients are commercially insured. More than 50% are covered by Medicaid. Approximately 5% of our patients are undocumented immigrants. The hospital also provides tens of millions of dollars of free care each year. Our mission is to improve the health status of our community, and to continue to provide quality health care irrespective of the economic status of a patient. We define health care in the broadest sense required to achieve improvement in the health status of our community. We are fortunate to be governed by a Board of Trustees, and supported by a founding community both of which explicitly recognize the ethical commitment to serve our local community, and live up to that commitment. We are proud that we are able to continue our traditional commitment to accept all patients regardless of their ability to pay.

We are a Level I trauma center, the highest level certified in the state of Illinois. We are also a Level III Perinatal Center, again the highest level certified in our state, providing care to high risk mothers

and infants. We operate eighteen primary care sites. Directly, and through our Community Health Foundation, Mount Sinai is one of the largest providers of community health care programs in the United States. Mount Sinai has received national recognition for our commitment to community based programs, most recently as the recipient of the American Hospital Association's national 1992 Foster McGaw Award for hospital excellence in community service. These programs include school based health education and pregnancy prevention, primary care in school based clinics, community based mental health services, case management of high risk pregnancies, WIC nutrition services, high risk pregnancy treatment and prevention, parenting education, a health and ministry program joining our resources with area churches, tenant organizing, community and housing redevelopment and Health Care Partnership building, bringing all providers together in the interest of the community.

The West and South Side neighborhoods that we serve are a microcosm of this nation's urban social and health care problems. These areas are predominantly African-American and Latino, with poverty rates ranging from 38% to 53%. A substantial number of undocumented immigrants live in the communities served by Mount Sinai and are treated at the hospital and in our community based primary care sites. While the rest of the country was working to lower an infant mortality rate of 8 deaths per thousand live births, the infant mortality rate in our community is over 20 deaths per thousand live births, going higher than 24 per thousand in one of our community areas. Nearly one third of the births in this community are to adolescent mothers - and up to 85% of the births in many of our communities are to single mothers. The rate of low-birthweight infants in the area tends to be 50% higher than that for the state as a whole.

Maternal and infant health are not the only areas of significant health problems among the underserved members of our community. Health status, in general, is very poor in these communities. Death rates from heart disease, cerebrovascular disease and cancer are more than double those in the rest of the state. Deaths rates due to homicide, cirrhosis, diabetes, hypertension, pneumonia, injuries, and firearm incidents are all extremely high.

It is impossible to talk about improving health status and outcomes in our communities without looking at the impact of the social and economic environment on the lives of our patients. There are an abundance of factors which affect health status, and the response of the health care system. These factors range from chronic poverty to lack of proper housing to inadequate education. What I would like to focus on today are two of these factors - substance abuse and violence - and discuss the implications they have for the health status of underserved communities throughout the nation and for the development of an effective system of health care reform.

I know that this committee will be hearing today about the national impact of substance abuse on health care costs. I do not need to describe to you the negative consequences of widespread substance abuse on our society at large. Likewise, I am sure you are already aware of the health consequences that substance abuse has on individuals. What I want to do instead is to provide a picture of what this problem means, in a community like ours, to the appropriate provision of health care services.

The communities served by Mount Sinai have a significant incidence of alcohol and substance abuse. There is virtually no service that we offer that is not in some way affected by this issue. Let me begin with maternal and infant health care. Mount Sinai is a major provider of maternity services in Chicago, with over 3,500 deliveries a year. As a Level III perinatal center, we also provide a significant amount of care to high risk mothers and infants. The continuing vision of sick mothers and sicker babies has driven us for many years to seek earlier interventions, prevention, solutions to the cycle of endless human loss and also to the enormous cost that surrounds the early birth of low birthweight and poorly cared for babies. While we are often successful in helping our patients develop the skills and attitudes that result in the delivery of a healthy baby; while we often succeed in helping create a protective environment that results in the delivery of a healthy baby; while we are often successful in helping young women and even younger girls identify life goals that help them make healthful decisions avoiding unwanted pregnancies, we have also learned that this critical improvement in health status is not simply attained by the issuance of an insurance card. There are many factors in our community, and others like it, that have a powerful effect on the actions and decisions of the people who live there.

Approximately thirty percent of the infants born at Mount Sinai show evidence of maternal substance abuse. Maternal substance abuse is a major factor in the admission of many of the children on our infant intensive care unit. Analysis of data on our own patients, along with other studies, has demonstrated to us that simply making prenatal care available does not have a significant impact on maternal substance abuse, nor does it significantly improve maternity outcomes. A large scale, long term study in Massachusetts, recently published in the Journal of the American Medical Association, again validated the failure of providing coverage for prenatal care to make a significant improvement in maternity outcomes. It is clear that potent adverse social forces must be addressed directly in order to be overcome. So, we have committed our institution to offering programs that go beyond the normal range of services needed by the average maternity patient.

Chicago, like most big cities, has an extreme shortage of substance abuse treatment slots for low

income pregnant and parenting women. When our obstetricians, pediatricians, or case managers identified a woman who was not only in need of such treatment, but was actively seeking it, we were unable, even for this motivated group, to find available programs. Therefore, with the support of a Health and Humans Services grant, Mount Sinai started its own program, called Fresh Start, to provide outpatient substance abuse treatment for our maternity patients. This program combines therapy sessions, parenting education, day care, case management and intensive home visiting services in an effort to support the commitment of these motivated women to solve their problem. Through their work in the Fresh Start program, these parents do succeed in avoiding costly and tragic outcomes.

It is also critical to note that having a substance abuse problem greatly diminishes the likelihood that a woman will seek prenatal care, even if she has access to it. As I noted earlier, Mount Sinai does not turn away patients without insurance, whether at our primary care sites, or at the hospital. We have an extensive primary care network providing access to prenatal services. In addition, the great majority of our maternity patients are eligible for Medicaid. Despite this, a significant percentage of our maternity patients present in our emergency department without prior prenatal care, or seek care very late in their pregnancies. One recent study found that pregnant women who are using drugs are seven times less likely to receive prenatal care than women who do not use drugs. This is of great concern to us. We have no chance of reducing the risk factors of pregnancy if we cannot provide prenatal care. Therefore, we attempt through a variety of outreach and case management activities, to engage these women in prenatal care. Case managers work with these, and other high risk mothers, to confirm appointments, provide transportation, provide day care, nurture the particularly vulnerable patients who need support and eliminate other barriers to effective prenatal care.

As I stated earlier, a significant number of the infants born at Mount Sinai show evidence of maternal substance abuse. In order to create any possibility of such an infant maturing successfully into a healthy, productive adult we must recognize the need to address the ongoing developmental problems this will cause for many of these children. Therefore, Mount Sinai and Schwab Rehab jointly run an early intervention program for high risk children, from birth to age three. This program provides comprehensive health, therapy, and family support services and is supported by funding through the federal Part H Early Intervention Program. Virtually every child currently enrolled in the program has health and developmental problems related to maternal substance abuse.

Mount Sinai also operates both an inpatient and outpatient program for the identification, assessment, and treatment of child abuse. The immediate community that the hospital is located in is one of the

communities at highest risk for child abuse in the state of Illinois. According to the National Committee for the Prevention of Child Abuse, substance abuse is one of the major risk factors in our community for child abuse.

What we cannot yet document, but know from anecdotal observation, is the continuing impact of substance abuse within a family on the health of children. In addition to classic abuse and neglect of the children, we are aware that substance abuse affects the ability of the parents to recognize the need for, and seek appropriate care and services for their children, and affects a host of issues within a family.

Mount Sinai is also a Level I trauma center, with over 2,000 trauma injuries seen each year. Later on in my testimony, I will return to this area to discuss the impact of violence in our community. However, it has become clear to us that both alcohol and drug use play a major role in the incidence of trauma. We recently studied trauma patients treated in the first seven months of this year. Of the 1,094 trauma patients seen in that time period, 656 showed evidence of alcohol use and 687 showed evidence of other drug use. We are currently analyzing what percentage showed evidence of both alcohol and drug use.

Our experience with our general medicine patients also bears out what the Columbia University Center on Addiction and Drug Abuse study showed. Substance abuse causes complications for our patients admitted for a wide spectrum of conditions.

At our Schwab Rehabilitation Hospital and Care Network, substance abuse is a significant issue in the rehabilitation of both pediatric and adult patients. Many of the children referred from our acute care facility are treated at Schwab for problems related to maternal substance abuse. Many of the injuries resulting in the need for rehabilitation have substance abuse as a cause. Schwab is currently involved in a treatment and research program for substance abuse among head trauma patients.

The second public health issue I would like to discuss that is of particular concern to us is the impact of violence on the lives of the young men in our community. It is no secret that violence is the single major public health problem for these young men. As a Level I trauma center, we are acutely aware of this fact. Most trauma centers primarily treat victims of motor vehicle accidents. At Mount Sinai, we are far more likely to be treating victims of what the state of Illinois politely calls penetrating trauma — gunshot wounds and knife wounds. Well over half of the trauma patients we treat at Mount

Sinai are the victims of penetrating trauma. Sadly, many of these patients are seen more than once through our trauma center. We have begun to track such patients, for whom trauma is, amazingly enough, a chronic recurring disorder. We recently had an incident where a leader of a local gang and two members of his group, all with gunshot wounds, having survived an assassination attempt drove themselves to Mount Sinai for treatment, knowing from their own experiences and those of their friends which emergency room to go to for gunshot wound treatment. A significant percentage of the rehabilitation patients treated at Schwab are also victims of violence. We now have reached the point where gunshot is the major cause of spinal chord injury seen in our community. Such events cause a rolling impact throughout the community and throughout our institutions. It is not merely the unreimbursed cost of providing the "\$100,000 plus" acute treatment for the major gunshot victim. It is not simply the \$1Million in lifetime rehabilitation and maintenance costs that we will all have to share in. There is the recurring cost of transporting patients and staff who no longer feel safe going to and from health care facilities. There is the recurring expense of having to provide extraordinary security to protect those facilities, staff, patients, and visitors. There is the escalating cost of paying staff adequately to compensate for the additional risks they perceive. Above all else there is the immeasurable toll taken on the community by the pervasive fear of violence. The isolation of the elderly, the shutting in of children by protective parents, the passing along of the ethos of violence to a new generation all reflect themselves in the diminished vitality of the people of communities like ours, and cost our broader society dearly.

We present this picture of the health of our community to call attention to the fact that the problems of the underserved are complicated, multi-faceted, and difficult to address. While we believe that the President's Health Security Plan takes many major and important steps towards comprehensive reform of the health care system, we feel it is important that the special needs of underserved communities such as ours receive greater recognition and attention. If we are to have a true impact on health status, and on outcomes for our patients, we must recognize some important principles.

The first principle is that guaranteed coverage for care is not the same as guaranteed access to care, and that even access does not always guarantee the use of effective health care. As we see with many of our patients, other barriers besides coverage exist for care. Women with a substance abuse problem who are unwilling or afraid to seek care do not have true access. Women whose substance abuse causes them to engage in behaviors that interfere with seeking care do not have true access. A commitment to outreach, case management, and the provision of supplementary services is critical

to providing the access to care that we believe is necessary to improve the health of our people..

The second principle is that even access to and use of customary effective health care may not significantly affect outcomes and health status in chronically underserved communities. As we noted above, prenatal care alone has little significant impact on maternal substance abuse. A broad range of services is necessary to effectively engage patients. A recent article in the July 7, 1993 Journal of the American Medical Association demonstrated that mere access to care through expanded insurance coverage did not have an appreciable effect on poor pregnancy outcome. This data comes as no surprise to us at Mount Sinai. We have long been aware that a specifically tailored comprehensive set of services is necessary to affect outcome among vulnerable patients. We have been fortunate enough to have support for a large network of community health services that supplement basic medical care, and have been demonstrated to be highly successful in their impact on health outcomes. For example, Mount Sinai has provided intensive case management services for women at high risk of poor pregnancy outcome. Case managers ensure that patients receive a complete assessment of their medical and social service needs, arrange appointments, provide follow-up if appointments are missed, make arrangements for transportation or child care, and provide referrals to related services, such as nutrition or substance abuse treatment. In one typical year, when the program enrolled 150 high risk women, among whom the normal expectation would have been 30 high risk births, not a single low birthweight infant was born to program participants. Each of these women was at extremely high risk of delivering a low birthweight infant. The cost of delivering these specifically tailored services is minimal - less than \$25,000 a year for the whole group. The savings for preventing even one low birthweight delivery can be well over \$100,000. The savings in terms of quality of life for these children and their families is incalculable. The savings to society in avoiding institutional dependency is unimaginable.

We must also broaden our definition of care if we are to truly affect outcomes. Our trauma center has excellent statistics for patient survival of gunshot wounds. These are meaningless, however, if we cannot affect the risk behavior and the social conditions that send these young men through our emergency room again and again.

The third principle is that, even with health insurance coverage, many of these patients may not be actively sought after by health care providers, and are certainly unlikely to receive the range of services they need from all providers. The underlying social conditions of our community cause many of our patients to have a higher acuity of illness, and to be in need of an expensive range of services.

Effective treatment will also demand a commitment from providers to make these services "user friendly" with additional amenities such as transportation, case management, intensive social services, and day care. These are not services that all providers are experienced in, or have demonstrated a commitment to provide.

It is an unfortunate fact of our health care system that many institutions feel that more affluent patients will not choose services at a hospital with a large population of poor patients. Additionally, poverty and uninsured status, which will continue to follow many patients such as undocumented immigrants, is often perceived to be associated with social groupings with which many institutions do not desire to be identified.

What then, are the implications here for health care reform as it affects our inner city and disadvantaged communities. **First**, we must acknowledge that health insurance coverage will not guarantee access to care. If we genuinely wish to improve the health status of the underserved communities in our nation, health reform must support those additional services that are needed to actively engage patients in a system of care. This is not only an ethical issue, it is a matter of self interest. We cannot lower the cost of health care without lowering the level of service is improving the health of our nation.

Second, we must recognize the need to support those institutions that have demonstrated the expertise and commitment to providing those services which bring us closer to that goal. The President's plan calls for the elimination of disproportionate share payments, based on the notion that provision of universal access eliminates the problem of unreimbursed care. But the current disproportionate share program recognizes more than the need to provide support for coverage for the uninsured. It recognizes the higher costs associated with treating very vulnerable populations. It recognizes the complex range of services that are necessary to adequately affect health outcomes. It recognizes the greatly increased cost of operating in the adverse environment that is often associated with underserved communities.

Third, the concept of essential community providers must be encouraged and expanded. There is no reason to believe that coverage will automatically make all patients equally desirable to health care providers, or that all providers will be committed to the complex range of care and services necessary to serve many of our patients.

I want to thank the Committee for this opportunity to discuss the special health care needs of many of our communities, and the need for a system designed to improve the health status of the most vulnerable members of our society. Thank you.

NATIONAL ASSOCIATION OF URBAN CRITICAL ACCESS HOSPITALS

Private, Not-For-Profit Hospitals Working In Partnership With Government

National Association of Urban Critical Access Hospitals: An Overview

Due 3/28/94

Urban Critical Access Hospitals Defined

Urban critical access hospitals are located in cities; they are private and non-profit; they have no automatic or statutory access or entitlement to direct local or state funds for general operating purposes; at least 55 percent of their patient days are reimbursed by Medicare and Medicaid; at least 10 percent of their patient days are Medicaid days; and their total hospital days must be at or above the 60th percentile of hospitals in comparably sized Metropolitan Statistical Areas (MSAs). They also provide significant amounts of charity care.

The manner in which urban critical access hospitals are reimbursed gives them a special relationship with the federal government because they are, in effect, almost totally dependent on government for their reimbursement – and for their survival.

Urban critical access hospitals are *not* public hospitals and should not be confused with public hospitals. While they can be found in similar communities, providing similar services to similar people for similar compensation, they lack the similar ability to draw directly on public resources for financial assistance. When public hospitals lose money on operations, they turn to local or state governments for direct financial subsidies; when critical access hospitals lose money on operations, they have no similar patron to which to turn. When public hospitals wish to build, to renovate, or to introduce new services that their patients and communities need, they have a public source of funding for such improvements; urban critical access hospitals, though they fill identical roles in their communities, have no such source and receive no comparable government support or guarantees. On average, over 25 percent of public hospitals' general operating funds come from direct local or state subsidies; critical access hospitals enjoy no such subsidies.

The Problems That Urban Critical Access Hospitals Face

Today's health care environment has left urban critical access hospitals in critical financial condition. The adequacy of Medicare payments varies greatly, depending on a given hospital's case mix and geographic location, and Medicare is constantly threatened by federal cutbacks; many states significantly under-reimburse providers for Medicaid services; and hospitals in low-income communities are not reimbursed at all for care that they provide to many people who turn to them for help. Urban critical access hospitals have

little opportunity to engage in the cost-shifting that enables hospitals with greater numbers of privately insured patients to survive government's historically inadequate reimbursement – and no opportunity to have compensation for those inadequate payments supplemented by a public benefactor.

As a result, critical access hospitals work with much smaller operating margins than their counterparts with more favorable payer mixes; frequently, those operating margins are too small to meet their capital needs. Some of these hospitals survive only with the help of dwindling endowments, bequests, gifts, and contributions.

These hospitals suffer many financial hardships precisely because they are urban. They are located in areas with high crime rates and must devote significant resources to security and building repairs; they pay larger insurance premiums; and they lose privately insured patients because of their location. The lengths to which they must go to recruit and retain qualified staff often are overlooked in the labyrinthian calculations of Medicare wage indexes, insurance industry rate formulas, and other such measures that determine how they are paid – and, too often, underpaid – for the care that they provide.

Inadequate reimbursement and operating losses make it difficult for critical access hospitals to find the capital that they need to fund improvements. Potential lenders, wary of unfavorable payer mixes, uncertain locations, and unmanageable uncompensated care burdens, view critical access hospitals as high-risk borrowers to whom funds should be denied or offered only at impossibly high rates of interest. As a result, critical access hospitals frequently carry unusually large outstanding debts for their capital improvements.

This, in turn, further damages the ability of critical access hospitals to attract the privately insured patients they need to improve their finances and to introduce improvements needed to serve their communities better. Physical plants get older and can no longer meet the growing demands of modern medicine. Cost-saving measures that would enable the hospitals to compete for managed-care contracts cannot be implemented. New services needed by the community cannot be introduced, further impairing the hospitals' ability to serve their communities and attract new patients. For American hospitals, capital funds are like basic nutrition: deprived of them for a brief period of time, they will struggle but probably endure; denied access to them altogether, they will certainly die.

Critical Access Hospitals – Too Important To Lose

And what if some hospitals die? Many people do not view this as a problem – after all, America has thousands of hospitals, some of which close their doors every year. Surely the loss of a few more would not matter.

But it would – if they were urban critical access hospitals.

By definition, urban critical access hospitals are the health care providers of last resort for many of their patients. Because of where they are located and the specific services that they offer, critical access hospitals often are the only providers to whom residents of

their communities can turn when they are sick. In this sense, the qualifying criterion that critical access hospitals' total patient days must be at or above the 60th percentile of hospitals in comparably sized MSAs speaks to the importance of these hospitals within their communities. It signifies that they are large and that they are heavily used, and that the residents of their communities depend on them; to an unusual degree in comparison to other providers. The loss of such hospitals would be a devastating blow to those communities that other providers may not be able to absorb.

What makes these communities different or special? They are in economic and social disarray, reeling from the effects of high rates of poverty, low rates of educational attainment, and few employment prospects. They suffer from major health problems, most notably high rates of infant mortality, AIDS, substance abuse, violence, and mental illness.

The hospitals that serve these communities also are different and special. Often, they are their community's leading employer. Most important, they offer services that are critically needed and otherwise unavailable – prenatal and obstetric care, pediatrics, health screenings, AIDS and tuberculosis services, drug and alcohol detoxification, psychiatric services, and emergency care. They often provide extensive and numerous outpatient and primary care services – a form of care for which government reimbursement has historically been even more inadequate than for inpatient care. In many cases, neighboring hospitals have abandoned such services because of the patients – and the payers – whom they attract. If critical access hospitals were to close, the financial problems that caused their demise would simply follow their former patients to other hospitals.

Finally, urban critical access hospitals are essential for the training of future medical professionals – not just doctors, but also nurses and the scores of other allied health professionals that constitute the American health care delivery system. Historically, health care professionals who work in urban environments were trained in such settings, and without these training programs, urban critical access hospitals will face an even greater shortage of qualified professional help than they encounter today.

Conclusion

Urban critical access hospitals are a vital, irreplaceable part of the American health care system. In a very real sense, they are partners of government. Their role in the delivery of care in this nation is unique, and the needs that arise from this special role are unique as well. Whether in weighing the merits of individual pieces of legislation or as part of the debate on the future direction of the health care system in this country, the special needs of these hospitals must be satisfactorily addressed if the communities they serve are to continue receiving the health care services they need.

Mr. JACOBS. Mr. Fertel.

**STATEMENT OF STANLEY FERTEL, PRESIDENT, JEWISH
MEMORIAL HOSPITAL, ROXBURY, MASS.**

Mr. FERTEL. Thank you, Mr. Chairman. Good afternoon. My name is Stanley Fertel. I am the president of Jewish Memorial Hospital and Rehabilitation Center, a 207-bed chronic disease hospital located in the Roxbury neighborhood of Boston, Mass. We participate as a long-term hospital under the Medicare program and over 90 percent of our patients are admitted from inner-city, acute care hospitals.

Like the neighborhood of Harlem that Chairman Rangel represents, Roxbury is a neighborhood characterized by pervasive unemployment, rampant poverty and high crime, compounded by problems associated with substance abuse. Roxbury has the highest homicide and violent crime rate in the city of Boston.

I want to talk today about a fundamental point for inner city health care providers—the well-being of our patients in a reformed health care system. Jewish Memorial Hospital's patients are highly complex, medically involved with multiple illnesses due to disease or trauma and require an intensity of care not generally available in other settings.

They include patients with AIDS often caused by substance abuse, patients with drug-related infections, patients with multiple trauma, often related to drugs, alcohol, gunshots, and drug overdose, and ventilator-dependent patients resulting oftentimes from drug trauma. We also focus on the health needs facing a minority community, including patients with hypertension and related diagnoses, such as stroke, diabetes and cardiac failure.

We operate a program for pediatric outpatient services for multiply handicapped, developmentally disabled, low birthweight babies born of mothers who are often drug abusers. I am enclosing with my testimony a brochure describing this program.

Like many chronic disease and rehabilitation hospitals, we essentially have only two payors—Medicare and Medicaid. The Medicare program accounts for approximately 78 percent of all admissions to our hospital. When these patients have a prolonged stay, they exhaust entitlement to Medicare benefits and become Medicaid dependent. As a result, it is crucial that our hospital have stability and payment source and benefit requirements under health care reform.

We are concerned that the proposed managed competition approach will result in inner-city chronic hospitals seeing a diversion of their shorter stay, less expensive cases to hospitals in other areas that participate in a managed care network and which may not be able to treat those patients as well or as fully as we are able.

One characteristic of our patient is that they cannot be treated in another setting because of their needs for hospital level, long-term rehabilitative care, focusing on multiple body system failures. Health care reform should create demand for long-term hospitals as more prospectively determined payments to acute care hospitals encourage quicker discharges of patients who still need hospital level of care. But even more importantly, rather than finding the

most cost-effective placement for a patient, health care reform should result in the most medically effective placement for a patient.

I believe that health care reform's bottom line shouldn't be merely a financial one. It should and must be the well-being of our patients. Long-term hospitals are uniquely qualified to treat the range of rehabilitative and chronic hospital programmatic services that our patients require.

It is not clear that the Clinton reform plan recognizes this. So that the Jewish Memorial Hospital as an inner-city, long-term hospital may properly fulfill its mission, I would ask that your committee consider, first, inner-city chronic hospitals with a duly entitled Medicare and Medicaid patient level in excess of 25 percent should be deemed essential providers. Health plans should be required to contract with these providers.

Second, reinstatement of the provision of the Medicare Catastrophic Coverage Act that repealed the Medicare hospital day limit would free my hospital from unreasonable and unfair Medicaid reimbursement and utilization review guidelines and policies.

The 60-day spell of illness limitation under the Medicare program is inconsistent with the nationally guaranteed benefits package in the President's bill. I would recommend that the day limitation for Medicare hospital benefits be repealed.

Third, please reject attempts like those proposed in President Clinton's earlier proposal to reimburse long-term hospitals in the manner of skilled nursing facilities. Furthermore, the newer proposal to place a moratorium on designation of long-term hospitals fails to recognize the role these facilities can play in a reformed health care system.

We would like to work with Congress to devise a more workable policy. Fourth and finally, retain tax exempt status for hospitals that treat large, low-income populations. Our mere presence in Roxbury by definition is a benefit to that community, which is the IRS test for tax exempt status as set forth in revenue ruling 69-545.

I wish to thank you sincerely for the privilege of appearing here before your committee and I would entertain any questions. Thank you.

[The prepared statement follows:]

TESTIMONY OF STANLEY FERTEL
PRESIDENT, JEWISH MEMORIAL HOSPITAL
THE ROLE OF INNER-CITY CHRONIC HOSPITALS IN A
REFORMED HEALTH CARE SYSTEM
HEARING BEFORE THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON SELECT REVENUE MEASURES
NOVEMBER 9, 1993

Good morning. My name is Stanley Fertel, the President of Jewish Memorial Hospital in the Roxbury neighborhood of Boston, Massachusetts. We are a 207-bed chronic disease and rehabilitation hospital that is certified as a "long-term hospital" under the Medicare program. Over ninety percent of our patients are admitted from inner-city acute care hospitals.

Like the neighborhood of Harlem that Chairman Rangel represents, Roxbury is a neighborhood characterized by pervasive unemployment, rampant poverty, and high crime compounded by problems associated with substance abuse. Roxbury has the highest homicide and violent crime rate in the City of Boston.

I want to talk today about a fundamental point for inner city health care providers: the well-being of our patients in a reformed health care system.

Jewish Memorial Hospital's patients are highly-complex, medically-involved with multiple illnesses due to disease or trauma and require an intensity of care not generally available in other settings. They include:

- Patients with AIDS, often caused by substance abuse;
- Patients with drug-related infections;
- Patients with multiple trauma, often related to drugs, alcohol, gunshots, and drug overdose;
- Ventilator-dependent patients, resulting from drug trauma.

We also focus on the health needs facing a minority community, including patients with hypertension and related diagnoses such as stroke, diabetes, and cardiac failure. We operate a program for pediatric outpatient services for multiply-handicapped, developmentally disabled low birthweight babies born of mothers who are often drug abusers. I am enclosing with my testimony a brochure describing this program.

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As a result, it is crucial that our hospital have stability in payment source and benefit requirements under health care reform. We are concerned that the proposed "managed competition" approach will result in inner-city chronic hospitals seeing a diversion of their shorter stay, less expensive cases to hospitals in other areas that participate in a managed care network, and which may not be able to treat those patients as well or as fully as we are able.

One characteristic of our patients is that they can not be treated in another setting because of their need for hospital-level, long-term, rehabilitative care focusing on multiple body system failures. Health care reform should create demand for long-term hospitals, as more prospectively-determined payments to acute-care hospitals encourage quicker discharges of patients who still need hospital-level care.

But even more importantly, rather than finding the most cost effective placement for a patient, health care reform should result in the most medically effective placement for a patient. I believe that health care reform's bottom line shouldn't be a financial one; it should be the well-being of our patients. Long term hospitals are uniquely qualified to treat the range of rehabilitative and chronic hospital programmatic services our patients need. It is not clear that the Clinton reform plan recognizes this.

So that the Jewish Memorial Hospital, as an inner-city, long-term

hospital may properly fulfill its mission, I would ask that your Committee consider:

First, inner-city chronic hospitals with a dually-entitled Medicare and Medicaid patient level in excess of 25% should be deemed "essential" providers; health plans should be required to contract with these providers.

Second, re-instatement of the provision of the Medicare Catastrophic Coverage Act that repealed the Medicare hospital day limit would free my hospital from unreasonable and unfair Medicaid reimbursement and utilization review guidelines and policies. The 60 day spell-of-illness limitation under the Medicare program is inconsistent with the nationally-guaranteed benefits package in the President's bill, and I would recommend that the day limitation for Medicare hospital benefits be repealed.

Third, please reject attempts like those proposed in President Clinton's earlier proposal to reimburse long-term hospitals like skilled nursing facilities. Furthermore, the newer proposal to place a moratorium on designation of long-term hospitals fails to recognize the role these facilities can play in a reformed health care system. We would like to work with Congress to devise a more workable policy.

Fourth, retain tax-exempt status for hospitals that treat large low-income populations. Our mere presence in Roxbury, by definition, is a benefit to that community, which is the IRS test for tax-exempt status as set forth in Revenue Ruling 69-545.

This concludes my testimony today. I would be pleased to answer any questions you may have.

Mr. JACOBS. Thank you, Mr. Fertel. I wish to thank you sincerely for staying within your 5 minutes.

Dr. Streck.

STATEMENT OF WILLIAM F. STRECK, M.D., PRESIDENT/CHIEF EXECUTIVE OFFICER, MARY IMOGENE BASSETT HOSPITAL, COOPERSTOWN, N.Y.

Dr. STRECK. Thank you, Mr. Jacobs. I speak to you today under the rubric of the subcommittee's request to address health and well-being of residents of inner cities and other distressed neighborhoods, and it is under that latter rubric that I would speak to you about rural health care and some of the implications of the Health Security Act for residents of rural America.

I am from New York, but it is not well-recognized that 44 of the 62 counties in New York are rural and 3 million people and 17 percent of the population reside in rural areas. Rural poverty has been increasing nationwide since the mid-1980s, and, in fact, the rates which now vary from 12 percent in the Northeast to 22 percent in the South find some comparability in that the nonmetropolitan poverty rate in many cases equates with that of the inner cities, and, in fact, if you look at the most rural populations, the characteristics of high unemployment, low-median income, and lack of formal education are very similar.

I address you as the president of an integrated health care system that is rurally based, academically oriented with research activities in terms of disease prevention and epidemiology, and in graduate medical education and education of other providers. This system provides care to approximately 400,000 patients per year, and the majority of those patients are Medicare and Medicaid patients.

On that basis I would presume to offer three comments, two concerns, and four suggestions in my particular presentation. The comments are, first, supportive comments about the Health Security Act as proposed. I believe that the vision of universal coverage for the uninsured and in particular for the underinsured as this applies to rural areas is clearly an important step forward and a cornerstone of the proposal.

As has been emphasized by others, financial access does not equate to access to care, and thus the second point I would emphasize is that the provision of incentives for the development of primary care providers and the location of such providers in underserved areas is again, I believe, an important and positive element of the plan as proposed.

Finally, third, a positive element is the fact that there is recognition of the rural hospitals as the backbone, the infrastructure of health care in rural areas, and the President's proposal favors the investment in infrastructure and communication networks to insure increased use of those services. Those three positives are important.

There are two concerns, neither of which will be new to this committee or to others. The first is the fact that the Medicare and the Medicaid reductions proposed will not be balanced by funding through universal access. There is some concern expressed in the deliberations and the announcement of this committee that tax ex-

empt status would become an issue if hospitals were fully reimbursed for their services, and I would suggest that it will not become an issue under the proposal and that the Medicare and Medicaid reductions will outweigh any increase in other revenues, and the hospitals in the not-for-profit voluntary sector will continue to offer services as required.

Finally, managed competition suffers for some limits in the rural areas. It is difficult to apply cost-effective models and efficiency models to dispersed populations and there needs to be recognition of this fact.

I would conclude with the suggestions that by recognizing costs, by favoring integration of services through flexibility, and support of State initiatives, by supporting rural educational initiatives, and by recognizing the key roles of the hospital that the Health Security Act would be improved. The financing as proposed is not adequate, and thus does not put at risk the tax exempt status. I would suggest the greater concern is that we will see less service through reduction in funding, and this remains the fundamental question for all of us as we confront this question in 1993. Thank you for the opportunity to testify.

[The prepared statement follows:]

**TESTIMONY OF WILLIAM F. STRECK, M.D.,
MARY IMOGENE BASSETT HOSPITAL, COOPERSTOWN, NEW YORK**

**THE ROLE OF THE VOLUNTARY HOSPITAL:
The Bassett Experience**

Thank you for inviting me to join you today. As the President of a voluntary, not-for-profit, health care system in rural central New York, I have been asked to discuss the role and responsibilities of voluntary hospitals and how these may be affected as reform initiatives proceed.

At Bassett, for the last 70 years, we have been working hard to develop a model that addresses the health care needs of a traditionally underserved population -- rural residents, especially the rural poor and elderly. The problems which confront rural health care -- chronic underfunding, inadequate insurance coverage, shortages of primary care physicians and other health personnel, fragmented delivery systems, poor distribution of services and resources -- are, to a large degree, generic health care issues. They are not just rural, but urban, state, and national in scope. In short, poverty, illness, lack of insurance, and social and cultural barriers know no geographic boundaries. Rural areas also face long distances to services, geographic barriers, limited transportation, and extreme weather, all of which complicate the task of providing care.

Bassett is a fully integrated health care system in central New York which serves a population of approximately 350,000 people in a 10-county region the size of Massachusetts. The Bassett system is composed of a group practice of 150 salaried physicians; 14 community health centers in six rural counties; the Bassett Clinic, a primary and specialty care center in Cooperstown; Bassett Hospital, a 180-bed inpatient teaching facility in Cooperstown affiliated with Columbia University; O'Connor Hospital, 40 miles south of Cooperstown; a managed care plan with over 20,000 members; and research activities which focus on preventive medicine. An affiliation with Community Hospital of Schoharie County is currently under consideration.

It is also important to note that Bassett is a not-for-profit entity. One critical feature of the rural health care delivery system is that it is largely dependent on the voluntary, not-for-profit hospital. General Accounting Office studies have shown that the high proportions of Medicare and uncompensated care limit hospital revenues for rural hospitals. In New York state and across the country, efforts are underway to form various combinations of enterprises or networks of care to address some of these issues. Nonetheless, the Committee must recognize that it is the voluntary sector that is the framework for the provision of health care in rural areas.

In considering the Administration's health plan, one is encouraged that the fundamental issues which limit the development of rural health care services will be addressed. Foremost among these, of course, is the provision of universal insurance. Another element of the proposal which is relevant to rural areas is the approach to graduate medical education in teaching hospitals. Loan forgiveness programs for primary care physicians, development of programs to retrain mid-career specialists to become primary care physicians, and support of community-based undergraduate and graduate medical education training in primary care are important to ensure adequate numbers of providers. Training for nurse practitioners, nurse midwives, and physician assistants and rural health provider grants to support training programs for rural practitioners and implementation of medical communications technology are forward-looking steps.

Bassett has been a leader in the development of primary care networks; the use of non-physician providers, including nurse practitioners, nurse midwives, and physician assistants; the study of rural health care populations and their health care needs; and the training of paramedics, allied health professionals, advance practice nurses, and rural primary care physicians in the treatment of AIDS patients.

Another unique feature of Bassett is its salaried physician model. All Bassett physicians are salaried and practice full-time at Bassett facilities around the region. Patients benefit from the combined expertise of physicians who work together as a group throughout the integrated system. This is the model that is receiving increasing emphasis in health policy formulation.

The integration of the Bassett system is the key to our successful delivery of health care services. At the center of this system are our primary care providers -- physicians, physician assistants, and nurse practitioners -- who provide care at 14 community health centers and the

Bassett Clinic in Cooperstown. This primary care network provides easier access for people, especially the elderly and poor who lack transportation and those work long hours on the farm, in the factory or elsewhere and cannot take an entire day off to travel for care.

The Bassett Clinic, a primary and specialty care center, as well as Bassett Hospital, are located in Cooperstown, at the center of the 14 regional health centers. Through this system, all patients — regardless of their ability to pay — have access to primary health care and, when needed, a full array of diagnostic, specialty, and inpatient services.

As for inpatient care, we have taken steps to form affiliations with smaller, community hospitals in the region. These arrangements allow the hospitals to continue providing primary and acute care services locally while more advanced treatment is provided in Cooperstown. We believe that this is the best way to make sure that scarce, and often costly, resources are used most effectively.

Through our Research Institute we have ongoing activities which look at the health of rural populations. We conducted a health census of 44,555 residents to assess the health needs in our region and develop programs to address these needs. We have used the health census information to develop programs such as the Healthy Heart Program, designed to reduce peoples' risk of cardiovascular disease; the New York Center for Agricultural Medicine and Health, established to lower the high incidence of farming injuries and illness; a school-based primary care program; and a partnership program which teams up our researchers with educators from local school districts to enhance science education.

It is also important to note that because much of the research ongoing at Bassett focuses on rural populations, we provide a unique context for comparison studies with urban populations. For example, for several years now, Bassett's Research Institute and Harlem Hospital have participated in a National Institutes of Health-funded study which compares the causes of heart disease in black versus white patients.

I am talking about these programs to emphasize the fact that the not-for-profit element and the community-based aspects of the Bassett network compose the essential fabric of the health system in this country. These are the concepts against which we must measure the Clinton health care proposal.

A familiar theme to this committee is the fact that the proposed cuts in Medicare and Medicaid are damaging proposals. The benefits of extended insurance coverage for other parts of the population are undeniable. However, it is equally clear that this is not a compensatory strategy. It would presume that Medicare and Medicaid reimbursement are adequate for the provision of care, a point that is contestable, especially in rural areas. The analysis to date, at least in New York, indicates that there will be a significant shortfall in this transition. Dependent as the health system is on Medicare and Medicaid reimbursement, this is a dangerous component of the proposal as it stands at this time.

Another important point is that the provision of financial access through insurance vehicles does not ensure access to care in America. Making insurance available is not the same as ensuring the availability of care.

The relatively fragile rural hospital system can serve only as the framework for a more fully developed health care system in rural areas. The development of such systems is dependent upon the provision of primary care practitioners, adequate reimbursement and integration of these activities in the rural setting. The need to fund such programs is inherently recognized in the President's proposal, but the means to develop such programs have yet to be clarified. The solution to this question of access is to be found in direct investment in those areas where rural health education opportunities exist.

Finally, it is clear that there are technical considerations in the current health care reform proposal which need clarification. There are questions regarding the responsibilities of regional alliances in terms of provision of care in rural areas. It is one thing to offer an insurance product in a rural area; it is another to be involved in the provision of adequate care to an insured population. Rural populations must have assurances that health plans designated to serve

their communities will provide local access to services at the level provided to other plan enrollees.

However, I am not discouraged by the Health Security Act and its proposals. Rather, I am confident that the Bassett system, which has worked well for over 70 years, offers some insights to the problems facing both rural and urban communities. Integrated systems, primary care networks, managed care plans, salaried physician models, population-based research, and rural training and education programs are reform concepts which are already operational at Bassett.

In closing, there are several points that warrant emphasis. First, the rural health care system is essentially supported by the voluntary hospital system in this country. Secondly, Medicare and Medicaid funding are critical elements of this system. Providing coverage to the uninsured and medically indigent people in rural America will not compensate for proposed decreases in these funds. Thirdly, the provision of primary care practitioners and other non-physician providers is an important component of the Health Security Act. Training of such individuals is dependent upon adequate funding. And rural training programs are essential since there is an established correlation between training and practicing in rural areas. Finally, financial access to all citizens, particularly in rural America, does not guarantee that these individuals will have access to care. As long as the voluntary, not-for-profit hospital sector remains the key element in the provision of health care in America, a key component of any health care system must be providing some financial stability to these institutions. Ultimately, the success of any health care reform plan will depend upon its ability to address all of these critical concerns.

Mr. JACOBS. Thank you, Dr. Streck.

We are going to have to suspend, Mr. Cooper, for a few minutes to cast a vote. I will be back shortly.

[Recess.]

Chairman RANGEL [presiding]. We apologize. At this time we will take the testimony of Stephen Cooper, vice president of the New York State Hospital Association.

STATEMENT OF STEPHEN COOPER, VICE PRESIDENT, HOSPITAL ASSOCIATION OF NEW YORK STATE

Mr. COOPER. Thank you, sir. My name is Stephen Cooper. I am the vice president of the Hospital Association of New York State. Just so you know who we are, we represent all the hospitals in—all the not-for-profit and public hospitals of New York State. We do not represent for-profit hospitals. We represent 10-bed hospitals in the Adirondacks and we represent 1,500-bed hospitals in New York City.

Two weeks ago the President introduced his health reform plan. The central part of that plan is universal coverage. The President said universal coverage is nonnegotiable. I agree. Without universal coverage, health reform is meaningless and it isn't worth passing, but providing health insurance is only half the equation. There is no guarantee that people will have access to care, and based on past experience there is no reason to believe that primary care physicians or other physicians will move into inner-city areas or rural areas.

The President also said we need to be truthful about the numbers, about who wins, who loses. For the next several minutes I will address who wins and who loses. I will preface these remarks by saying that much of the distribution of money, funds in this bill, in the President's bill is formula-driven, which means these formulas can be changed.

As we analyzed the 1,342 pages, one trend became immediately apparent. Providers in inner cities and other distressed communities were going to pay for most of the administration's health reform plan. Although we are still finalizing our analysis, it appears that black and Hispanic congressional districts are the biggest losers under the President's plan.

More than half of the President's plan is paid for by reducing Medicare and Medicaid payments. Although there seems to be lots of new programs aimed at inner cities and distressed communities, in aggregate the President's plan reduces funding for services in inner cities and other distressed communities.

Under the administration's plan net payments to hospitals in New York State will be reduced by \$5 billion over the 5-year period. Net payments to hospitals in New York City will be reduced by \$3.8 billion, and net payments to those hospitals that serve large numbers of poor patients will be reduced by \$4.5 billion. That is over 90 percent of all the cuts.

In all likelihood this pattern is going to be—we will see this pattern in other States as well. Even if the administration's plan passes the Congress tomorrow, the epidemics of AIDS, tuberculosis, substance abuse, teenage pregnancy will not disappear. There are

200,000 heroin addicts in New York City and twice that number of cocaine users.

The experiences of State Medicaid programs have shown us that substance abusers will probably not wait in line to join health alliances and managed care programs. Under the administration's plan the health alliance will assign those who do not enroll in a health care plan to the lowest cost plan. In all likelihood this will be a Medicaid HMO, and like most HMOs there will be gate keepers directing the subscriber, the patient to the least expensive mode of care.

Now, without trying to sound too cynical, do we really expect the drug addict to call his or her primary care physician before going to an emergency room? Every year more than 15,000 substance abusers show up in New York City hospital emergency rooms suffering from overdoses and other drug-related episodes. Many times that number end up in our emergency rooms because of malnutrition, AIDS, and the result of street violence.

I fear that in a competitive environment the type of drug treatment offered will be the least expensive, not necessarily the most effective. Over the last several weeks I have started reading lots of literature about methadone maintenance. I wasn't sure if it was an effective program or not after I finished reading all of this literature.

What is undisputed is that methadone maintenance is one of the least expensive modes of treatment. In a competitive environment in order to survive, health plans will have little option but to seek the least expensive care, mode of care. There are no similar programs for those addicted to crack cocaine or multiple drug users. I could give you tons of statistics about how many people in New York are HIV positive, how many have TB, but you have heard them all morning long, and I will not bore you with them.

It may be unpopular to talk about illegal aliens, but they do exist. They live in our inner cities and rural communities. They live in fear, and they come to our hospitals only in emergency. I am sure the administration would like this problem to go away, but it won't, and the administration's solution is far from adequate. The administration and all of us would like to change the medical education program. The administration thinks by simply creating a mandate that 50 percent of all new physicians be primary care physicians. It isn't going to happen.

My belief is that will go the way of most other mandates issued by Washington. It may be in the end that certain urban centers like New York need to have a higher proportion of specialty programs. In order to do, for example, cardiac surgery you need a high volume of patients to do that.

In addition, our inner cities need these patients. How many physicians are going to willingly go to hospitals where half of the patients are drug abusers, one quarter are HIV positive, and half of the mothers delivering there are under 17 years old?

Let me address the last issue which is the issue of public and not-for-profit hospitals. That has come before this Congress before. Many of the boards and the executives of not-for-profit hospitals have been listening to the debate about health reform and think that competition is the way to go and maybe they should join the

fray in the marketplace. Some have, and in some instances it is very difficult to tell the difference between a not-for-profit and for-profit hospital. This has not escaped your attention and you have had a number of hearings about this.

I don't think the answer is to eliminate the tax-exempt status of hospitals. If a not-for-profit hospital or other provider is not serving the community, then it must change, not its tax status. New York State has a system where every not-for-profit hospital must prepare a community service plan, telling the community what it has done for it in the last year and what it plans to do for it during the next year.

In conclusion, there is a great many health reform plans before the Congress. Very few offer universal coverage. Without universal health care coverage, health reform is incomplete. The President's plan is far from perfect, but it is a good place to begin this debate. Thank you.

[The prepared statement and attachment follow:]

TESTIMONY OF STEPHEN COOPER, VICE PRESIDENT
HOSPITAL ASSOCIATION OF NEW YORK STATE

Two weeks ago, the President sent to the Congress a broad-based proposal to reform our nation's health care system. Under the Health Security Act, every American citizen and legal resident will be guaranteed a comprehensive package of health care benefits. As the President stated, this is non-negotiable. Any health plan that passes the Congress must provide for universal coverage. Without universal coverage, health care reform is meaningless.

But providing insurance coverage is only half the equation. There is no guarantee that health care services will be available in inner cities or other distressed communities. Based on past experience, there is no reason to believe that primary care physicians or other physicians will move into these communities. Unless health care services are available to the residents of these communities, security remains only an illusion.

The Hospital Association of New York State believes that the key to making universal health insurance work is to support and foster the mission of social responsibility which guides our non-profit and public hospitals in New York. New York's hospital system is predominantly a non-profit one; 95% of our acute care hospitals are voluntary, not-for-profit or public facilities. They provide services which are designed to meet specific community needs, often for care that goes far beyond the statutory requirement of providing acute care. In addition, whatever marginal surpluses our hospitals earn are reinvested in the community. This distinguishing characteristic of New York's health care system must be preserved in whatever health reform package emerges from Congress. This is the context in which the Hospital Association of New York State presents these comments on the impact of the President's Health Security Act to the Subcommittee on Select Revenue Measures.

Less Money for Inner City and Other Distressed Communities

The President's plan jeopardizes the very existence of many of the health care providers that serve inner city and other distressed communities. More than half of the Administration's plan is paid for by reducing Medicare and Medicaid payments. Although there appear to be many proposed new programs aimed at inner city and distressed communities, in aggregate, the Administration's bill substantially reduces support for inner city hospitals and other services. Furthermore, many of the cuts in Medicare and Medicaid will take effect years before all Americans are offered basic health benefits.

Under the Administration's plan, net payments to hospitals in New York State will be reduced by over \$5 billion, net payments to hospitals in New York City will be reduced by \$3.8 billion, and net payments to those hospitals that serve large numbers of poor patients will be reduced by \$ 4.5 billion (see attached chart.)

The Social and Medical Epidemics Are Not Going Away

Even if the Administration's plan passed the Congress tomorrow, the multiple epidemics of AIDS, tuberculosis, substance abuse, violence, and teenage pregnancy will not disappear.

Substance Abuse

There are at least 200,000 heroin addicts in New York City and twice that number of crack and cocaine users. The experiences of state Medicaid programs have shown that substance abusers probably will not wait in line to join health alliances and managed care programs. Under the Administration's plan, the health alliance assigns those who do not enroll in a health plan to the lowest cost plan. In all likelihood, the lowest cost plan would be, de-facto, a Medicaid Health Maintenance Organization (HMO). And, like most HMOs, this HMO would be a gatekeeper directing the subscriber to the least expensive mode of care. Without trying to sound cynical, do any of us expect a drug addict to call his or her primary care physician before going to the emergency room?

Every year, more than 15,000 substance abusers show up in New York City hospital emergency rooms suffering from overdoses and other drug-related episodes. Many times that number end up in our emergency rooms because of malnutrition, AIDS, the results of street violence, and the list goes on.

Universal health insurance is not going to solve the problem of drug abuse. But we should not penalize those hospitals that face this problem everyday, nor should we minimize the scope of this problem. A recent study published by the Robert Wood Johnson Foundation reported that the direct health care costs of substance abuse in 1990 was \$13.7 billion. The direct cost to hospitals of drug and alcohol abuse was \$6.8 billion. Approximately one out of every three patients treated in New York's hospitals is there for problems related to drug or alcohol abuse.

I fear that in a competitive environment, the type of drug treatment offered will be that which is least expensive and also may be the least effective. There is a great deal of controversy about the effectiveness and the appropriateness of methadone maintenance treatment problems. A number of studies suggest they are of little value and do little more than substitute one drug for another. Other studies suggest they are of value for some patients wanting to end their addiction to heroin. What is undisputed is that methadone maintenance is one of the least expensive modes of treatment. In a competitive environment, in order to survive, health plans may have little option but to seek the least expensive method of care.

There are no similar low-cost programs for those addicted to crack, cocaine, or multiple drug users. Under the Administration's proposal, I am not sure how we will address the problems of this population.

AIDS and Tuberculosis

There are more than 150,000 people in New York State known to be HIV-positive. Based on statistical projections, another 300,000 to 400,000 are HIV-positive and do not yet know it. One-third of those in treatment for substance abuse are HIV-positive and that proportion is probably higher for those substance abusers who are not in treatment. Perhaps even more frightening, more than 75% of the pediatric AIDS cases are attributable to drug use. Drug use has become the single largest cause of AIDS in New York State.

There are approximately 5,000 new cases of T.B. each year in New York. As many of 60% to 70% of these new patients are HIV positive. Approximately 40% are classified Multiple-Drug Resistant, i.e., they do not respond to the antibiotic therapies. These patients often remain in the hospital in excess of six months.

The statistics about teenage pregnancy, crime, and violence are equally frightening.

Illegal Aliens

It may be unpopular these days to talk about illegal aliens, but they do exist. They live in inner cities and rural communities. They live in fear and they come to our hospitals only in an emergency. I am sure the Administration would like this problem to go away, but it won't, and the Administration's solution is far from adequate.

A Commitment To Medical Education for the Community

There are currently 90,000 medical school graduates training in our nation's hospitals. The Clinton Plan calls for reducing that number to approximately 60,000 to 70,000 and altering the types of physicians we train.

New York is committed to medical education. Its 13 medical schools graduate 1,900 new doctors each year and its graduate medical education programs have over 15,000 residents-in-training. This is 60% more residencies than the next largest state and represents 15% of all physicians trained in the nation. In short, New York hospitals and medical schools are an important part of our nation's biomedical research infrastructure.

Physician training programs also benefit their communities - and benefit from being in the community. Many of our inner city hospitals and clinics in New York survive only because of the physician training programs they offer. Like inner cities, inner city hospitals are unable to attract physicians. Few physicians want to practice in hospitals where a third of the patients are HIV-positive, a quarter of the patients are substance abusers, and half of the maternity patients are less than 17 years old. Without physician training programs, inner city residents will have little access to health care services. The same is also true in many rural areas.

The federal government should consider the need for geographic "centers of excellence" in specialty training which would offer economies of scale, access to technology, proximity to biomedical research, and the volume of procedures and patients necessary for high quality teaching programs. This means that medical education programs may not be equally distributed across the country. Cities like New York City may need to sponsor a greater proportion of our medical specialty training programs

At the same time, we do need to encourage more medical students to enter primary care. Reducing payments to teaching hospitals will not accomplish this. Rather, it will reduce the number of physicians available to treat the inner city and rural citizens whose medical care is provided by teaching hospitals.

Encouraging medical students to become primary care physicians is not as simple as the Administration's plan makes it sound. A mandate from Washington that half of all new physicians be primary care physicians by the turn of the century may be as effective as most mandates from Washington. We should instead establish incentives to enter primary care. These incentives must encourage:

- changes in medical school admissions criteria, curriculum and faculty role models; and
- changes in where residents train, moving them from hospitals to clinics and the community.

Funds are needed also to cover the cost of converting specialty training programs to primary care programs. These incentives go hand-in-hand with student loan forgiveness, development of practice sites, and narrowing the differences in income between primary and specialty care physicians.

The Case for Not-for-Profit and Public Hospitals

Public and not-for-profit hospitals are committed to the communities they serve because their mission is not to make a profit but to serve. They do not leave their communities when those communities change.

However, many of the boards and executives of not-for-profit and public hospitals listening to the current debate over health reform and to the rhetoric extolling the virtues of competition are left wondering whether they, too, should join the fray in the marketplace.

Some have. In some instances, it is very difficult to tell the difference between a for-profit hospital and a not-for-profit hospital. This has not escaped the attention of the Congress, and over the last several years there has a great deal of discussion about the tax-exempt status of not-for-profit hospitals. This committee and other committees of the Congress have questioned the commitment of some hospitals to their communities. A number of members of Congress have suggested that if a not-for-profit entity is not serving its community then it should lose its tax-exempt status. I disagree. If a not-for-profit hospital or other

provider is not serving the community then it must change - not its tax status.

New York State requires every not-for-profit hospital in New York to annually prepare a Community Service Plan which is made public. Through this process, each hospital seeks input from its community as to health and related social service needs. In addition, the document serves as a report to the community regarding services that are already in place and what the hospital plans to do in the coming year. Many hospitals in New York know only too well their communities' needs: The epidemics of AIDS, tuberculosis, drug abuse, crime, violence, and teenage pregnancy make these needs all too clear.

The Community Service Plans are a reflection of the values held by our non-profit hospitals. Besides the traditional acute care services that are a hallmark of hospital care, our hospitals provide meals and clothing, transportation to health care services, and preventive care. For example, Champlain Valley Physicians Hospital Medical Center in Plattsburgh implemented a "Heart Smart" Program with the local middle school to modify children's eating habits and fost heart-health lifestyles. Clifton Springs Hospital and Clinic in the Rochester area provides dental services to migrant workers. Yonkers General Hospital, in cooperation with other hospitals, provides free immunizations to the homeless. The New York Hospital established the Will Rogers TB Outreach Program to test children who are at high-risk for TB. St. Luke's-Roosevelt Hospital Center operates a program to offer HIV testing and counseling to pregnant women.

Conclusion

There are many health reform plans before the Congress. However very few offer universal coverage to all Americans. Without universal coverage, health reform is incomplete. The President's plan is not perfect, but it is a good place to begin this debate.

PRELIMINARY ESTIMATES OF IMPACT OF MAJOR FEDERAL BUDGET PROVISIONS AND THE CLINTON HEALTH CARE REFORM PROPOSAL ON NEW YORK STATE HOSPITALS (In millions of dollars)

	FFY 1994	FFY 1995	FFY 1996	FFY 1997	FFY 1998	FFY 1999	FFY 2000	TOTAL 1994 - 2000
TOTAL NEW YORK STATE								
IMPACT OF THE PRESIDENT'S HEALTH REFORM PROPOSAL								
INCREASED REVENUE								
Expansion of Coverage (1)								
Payment to Hospitals Serving Vulnerable Populations (2)								
Payment Changes for Non-Medicare DME & IME (3)								
INCREASED REVENUE FROM HEALTH CARE REFORM	\$0	\$0	\$0	\$1,908	\$2,647	\$2,819	\$2,721	\$8,798
REDUCTION IN PAYMENT								
Health Care Reform Medicare Cuts (4)	\$0	(\$338)	(\$790)	(\$1,544)	(\$2,008)	(\$2,463)	(\$2,973)	(\$10,116)
Medicare DME Payments Under Health Reform (5)				(\$82)	(\$111)	(\$113)	(\$116)	(\$4,222)
Loss of Medicaid Disproportionate Share Payments (6)				(\$722)	(\$963)	(\$963)	(\$963)	(\$3,611)
Bad Debt and Charity Care costs for Undocumented Persons (7)				(\$722)	(\$131)	(\$181)	(\$189)	(\$700)
REDUCTION IN PMT. FROM HEALTH CARE REFORM	\$0	(\$338)	(\$790)	(\$2,479)	(\$3,283)	(\$3,728)	(\$4,251)	(\$14,849)
TOTAL IMPACT ON NYS HOSPITALS FROM HEALTH REFORM								
TOTAL IMPACT FROM OBRA '93 & HEALTH REFORM	\$0	(\$338)	(\$790)	(\$571)	(\$716)	(\$1,108)	(\$1,630)	(\$6,053)
IMPACT OF THE OBRA '93 BUDGET CUTS (8)	(\$170)	(\$359)	(\$621)	(\$728)	(\$785)	(\$681)	(\$730)	(\$4,084)
TOTAL IMPACT FROM OBRA '93 & HEALTH REFORM	(\$170)	(\$697)	(\$1,411)	(\$1,299)	(\$1,511)	(\$1,790)	(\$2,260)	(\$9,137)

Note: These estimates assume full coverage of the uninsured starting 1/1/97.

These estimates do not include the impact of growth in non health care premiums as proposed by the president. Health care expenditures per capita, even in countries with universal coverage, have growth rates higher than the general inflation. It is anticipated that providers will have significant revenue shortfall under the proposed growth limits. No change in Medicaid revenue is assumed except for the loss of the Medicaid disproportionate share payments. Outpatient Medicaid payments may increase under the reform. However, no funds have been set aside in the plan to cover this increased expenditure and it can only be funded through cross-subsidization, or through cost saving from increased efficiency.

(1) Estimates reflect the reduced bad debt and charity care need without the offset of uncompensated care costs for serving undocumented persons. However, there will continue to be uncompensated care costs for serving vulnerable persons (see below) and for coinsurance and deductibles.

(2) Allocated to New York State on the basis of New York's share of Medicaid disproportionate share dollars.

(3) Estimated based on the difference between the total non-Medicare payment for DME and IME under health reform and the revenue loss from a 1.5% reduction in payment to alliances (set aside for DME & IME purposes) as well as the potential revenue loss from the lower per capita premium target due to New York's disproportionately high graduate medical education costs.

(4) Major Medicare Health Reform cuts include the impact of reductions in update factor, reduction in IME payments, elimination of disproportionate share payments, limit on skilled nursing facility & home health payments & competitive bid for Medicare labs.

(5) Estimated based on national average payments

(6) Medicaid disproportionate share payments will be eliminated under the Clinton plan and replaced by payments to hospitals serving vulnerable population. These impacts are not trended because of the current cap on Medicaid disproportionate share payments

(7) Estimated based on the assumptions that there are 490,000 undocumented persons in New York State and a national average health care insurance premium per person of \$1800 in 1993 adjusted to reflect the higher health care cost in NY. Only 30% of this amount is assumed to be inpatient hospitalization and only 30% of that amount is assumed to be uncompensated Medicaid disproportionate share payments

(8) Major OBRA budget cuts include the impact of reduction in update factors, reduction in capital payments, DME payment changes, reduction in outpatient payments, reduction in payments for lab services and elimination of add-ons for hospital HHAs.

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PRELIMINARY ESTIMATES OF IMPACT OF MAJOR FEDERAL BUDGET PROVISIONS AND THE CLINTON HEALTH CARE REFORM PROPOSAL ON NEW YORK CITY HOSPITALS (in millions of dollars)

	FFY 1994	FFY 1995	FFY 1998	FFY 1997	FFY 1998	FFY 1999	FFY 2000	TOTAL 1994 - 2000
TOTAL NEW YORK CITY								
IMPACT OF THE PRESIDENT'S HEALTH REFORM PROPOSAL								
INCREASED REVENUE								
Expansion of Coverage (1)			\$1,188.2	\$1,641.3	\$1,713.9	\$1,800.6	\$6,343.9	
Payment to Hospitals Serving Vulnerable Populations (2)		\$63.3	\$111.0	\$111.0	\$111.0	\$111.0	\$416.3	
Payment Changes for Non-Medicare DME & IME (3)		\$113.5	\$90.4	\$67.2	\$52.6	\$32.7	\$323.7	
INCREASED REVENUE FROM HEALTH CARE REFORM	\$0.0	\$0.0	\$0.0	\$1,384.9	\$1,842.7	\$1,882.1	\$1,984.1	\$7,003.9
REDUCTION IN PAYMENT								
Health Care Reform Medicare Cuts (4)	\$0.0	(\$236.0)	(\$534.0)	(\$1,066.5)	(\$1,357.0)	(\$1,625.0)	(\$1,822.0)	(\$6,730.5)
Medicare DME payments under Health Reform (5)			(\$78.8)	(\$107.0)	(\$109.0)	(\$112.0)	(\$406.8)	
Loss of Medicaid Disproportionate Share Payments (6)			(\$601.7)	(\$802.2)	(\$802.2)	(\$802.2)	(\$3,008.3)	
Bad Debt and Charity Care costs for Undocumented Persons (7)			(\$131.2)	(\$181.2)	(\$189.2)	(\$198.8)	(\$700.3)	
REDUCTION IN PMT. FROM HEALTH CARE REFORM	\$0.0	(\$238.0)	(\$534.0)	(\$1,888.1)	(\$2,447.4)	(\$2,755.4)	(\$3,035.0)	(\$10,845.8)
TOTAL IMPACT ON NYC HOSPITALS FROM HEALTH CARE REFORM	\$0.0	(\$238.0)	(\$534.0)	(\$1,888.1)	(\$2,447.4)	(\$2,755.4)	(\$3,035.0)	(\$10,845.8)
IMPACT OF THE OBRA 1993 BUDGET CUTS (8)	(\$88.0)	(\$183.0)	(\$323.0)	(\$377.0)	(\$412.0)	(\$456.0)	(\$382.0)	(\$2,714.0)
TOTAL IMPACT FROM OBRA '93 & HEALTH REFORM	(\$88.0)	(\$418.0)	(\$857.0)	(\$860.1)	(\$1,016.7)	(\$1,189.3)	(\$1,452.8)	(\$6,882.9)

NOTE: These estimates assume full coverage of the uninsured starting 1/1/97.

These estimates do not include the impact of growth in health care premiums as proposed by the president. Health care expenditures per capita, even in countries with universal coverage, have grown at rates higher than the general inflation. It is anticipated that providers will have significant eventural shortfalls under the proposed growth limits. No change in Medicaid revenue is assumed except for the loss of the Medicaid disproportionate share payments. Outpatient Medicaid payments may increase under the reform. However, no funds have been set aside in the plan to cover this increased expenditure and it can only be funded through cross-subsidization, or through cost savings from increased efficiency.

(1) Estimates reflect the trended bad debt and charity care need without the offset of uncompensated care costs for serving undocumented persons. However, there will continue to be uncompensated care costs for serving undocumented persons (see below) and for co-insurance and deductibles.

(2) Allocated to New York City on the basis of New York City's share of DME & disproportionate share dollars.

(3) Allocated statewide impact estimates based on New York City's share of DME & IME dollars.

(4) Major Medicare Health Reform cuts include the impact of reductions in update factor, reduction in IME payments, elimination of disproportionate share payments, limit on skilled nursing facility & home health payments & competitive bid for Medicare labs

(5) Estimate based on national average payments.

(6) Medicaid disproportionate share payments will be eliminated under the Clinton plan and replaced by payments to hospitals serving vulnerable populations. These impacts are not trended because of the current cap on Medicaid disproportionate share payments.

(7) Estimated based on the assumptions that there are 490,000 undocumented persons in New York State (assumed that all are from New York City) and a national average health care insurance premium per person of \$1800 in 1993 adjusted to reflect the higher health care cost in NY. Only 30% of this amount is assumed to be inpatient hospitalization and only 50% of that amount is assumed to be uncompensated.

(8) Major OBRA budget cuts include the impact of reduction in update factors, reduction in capital payments, DME payment changes, reduction in outpatient payments, reduction in payments for lab services and elimination of add-ons for hospital HHAs.

Chairman RANGEL. You know, Mr. Cooper, I was trying to catch up in the testimony, but what was it you were saying was the need to continue to give it a tax exemption if a for-profit was doing the same thing? I missed that.

Mr. COOPER. OK.

Chairman RANGEL. If you have two hospitals and both of them are reimbursed and people—and they are providing the same service and one is for profit and one is not for profit, why the tax exemption?

Mr. COOPER. OK, the truth of the matter is they don't provide the same services to the same communities.

Chairman RANGEL. No, they don't. I am just saying if they did.

Mr. COOPER. If they did.

Chairman RANGEL. In other words, the tax incentive is to encourage things to be done that are not being done for the for-profits, but you would agree that if there was no difference that—

Mr. COOPER. If there was no difference between the two then I think the not-for-profit has to change its mission, not its tax status. My belief is that some outside force should come in and remind the board that they do have a not-for-profit tax status and they are there to serve the community, not to make a profit.

In my personal opinion, if they do not want to follow that mission, then the board should be reconstituted with people from the community. The tax exempt status, in my opinion, is not something that you have one year, then lose for a year, then come back the next year.

Chairman RANGEL. We may have a different opinion about it, but you get the tax exemption because of the mission that you say that you are going to follow. You don't do the mission, then we don't say, well, we have got another one that is just as good, but for God's sake we are not going to take the tax thing. I would think that anyone who enjoys tax exemption would not just wait for the Congress to give it new orders. If, indeed, their mission for whatever purpose is completed, then the tax exemption goes unless new reasons are given for it.

I don't see where the exemption would be just taken away. There are hearings and all type of other things, but I thought that is what you were saying, that don't take away the exemption, give them a chance to earn it for doing something else.

Mr. COOPER. In my view, it is a little different if they are not fulfilling their mission, then they must, they must be an asset to the community. That is in my opinion why they are there.

Chairman RANGEL. OK. Well, one of the concerns I had with previous panels and I am certain it was covered by this panel is what can we do in this bill or outside of this bill to reduce the number of people that are entering into this high risk community to be served?

In other words, I have not been able to get answers with the exception of coverage for those people in terms of prevention of illnesses. But, it seems like there is always a connecting thread that runs across all of these people that we are talking about—poverty, teenage pregnancies, low-weight babies, TB, cancer, drugs, gunshot wounds, homelessness, and we are always concerned with how do

these people get covered. Ultimately, I guess, we are going into the quality of the care.

It would seem to me that if this is one of the most costly parts of health care and if the ultimate goal is not just a healthy America, but to reduce the cost that someone should be talking about how you get people out of this thing. You don't have to be doctors or hospital administrators to figure out that someone should be working on this part of it, and besides having a doctor from Columbia, a Ph.D. from Columbia, we don't get too much testimony about that. Of course, we don't get too much testimony about what to do about crime except build more jails, and so most of the time when we have these bills, we say what do you do about drug addiction, say give higher reimbursement, and I understand that some of you spoke on this issue with Chairman Jacobs. Is that so?

Mr. GREENSPAN. Yes.

Chairman RANGEL. What was the suggestion that we could do in the Congress to make certain that there is not just a question of access to health care, but reduction in the type of health problems that we have? Was it you, Mr. Greenspan?

Mr. GREENSPAN. Mr. Rangel, if I can just tell you a couple of quick stories about programs that do exist, there are, beyond the Ph.D. deans in the schools of public health, there are a lot of people who currently work and are exceptionally creative in creating programs that are effective interventions. Crime is not an easy subject, substance abuse is not an easy subject, but, in fact, we can point to at least a handful of programs that do exist, and for which we fear funding will disappear as people make the assumption that universal coverage takes care of everything.

Let me point to just a few examples of our own. We have a program I have spoken to this subcommittee about before called the Window of Opportunity Program, the program that was addressing the incidence of early childhood pregnancy, pregnancies to children 11, 10, and 9 years old, a sure prescription for two generations of misery and expense. A very simple intervention, no doctors involved, use of health educators, hospital-sponsored, community-governed and sponsored in local school board governed schools, and in two cases so far we are looking at a school where the incidence of pregnancies in grade school went from 15 per year to 0 and another school in which it went from 3 per year to 0.

The cost of the program currently is \$50,000 per year per school. The savings on three childhood pregnancies per year, and when you compound them end up being in the millions of dollars.

Chairman RANGEL. What is the connection between poverty, teenage sex, and pregnancy?

Mr. GREENSPAN. We are stumbling along in the dark, but let me tell you what we see anyway. Let me throw one more anecdote your way before I answer, if I may.

We have a second program which is a program called the High Risk Pregnancy Intervention Program, and in this program we take high risk teenagers, high school students who are pregnant, have all the risk factors, and in whom you would expect 20 percent of the babies to be born high risk, infant intensive care unit babies. This is extensively an impoverished group of youngsters, usually with single-parent family households.

We track 150 children in a year, adolescents who were pregnant and were supported in a variety of ways which I can tell you about and zero low birthweight babies were born in the last year to this group. The connection to the youngsters in grade school who give birth, the connection to the teenagers in high school who give birth to high risk babies is the same. There is an inadequate social infrastructure to support them to establish a pattern of self-esteem and appropriate decisionmaking.

Poverty is present in virtually all the children. Substance abuse is a high risk factor in all of the young mothers, 30 percent of the babies we see are born to substance-abusing mothers. Crime is an extraordinarily present factor in their lives, and what we are doing is an intervention on the level of judgment, decisionmaking, self-esteem and old-fashioned professional nurturing.

The cost of the High Risk Pregnancy Program, by the way, for the aggregated 150 teenagers was \$25,000. We estimate avoiding 30 high risk babies per year.

Chairman RANGEL. Well, as you go to these conferences do you find any national leaders that are talking about trying to develop something on the national level that you are doing locally?

Mr. GREENSPAN. Yes, sir. You asked a similar question earlier of Dr. Heaton, and I want to tell you that there is an association of public health, the APHA, in which there is a subsection in maternal child health. I would certainly be happy to make some recommendations and write to the committee about some of the individuals. There are also local leaders in family and maternal care in Chicago and other major cities who I think could speak eloquently and much more adequately than I can about the national trend.

Chairman RANGEL. But is there anyone that talks to the broader extent about the connection between poverty and high health care such as Dr. Freeman? He just tied in cancer, you know, with poverty. People tie in drugs with poverty and they tie in failure for academic achievement with poverty and crime with poverty. Do you know in the course of your professional dealings who speaks as eloquently about this as most people talk about the need for adequate reimbursement for medical services?

Mr. GREENSPAN. There are a number of people. I am familiar with them because, like Dr. Heaton, I come from a school of public health, and there are people who have spent their careers researching the interaction between poverty and health status.

Chairman RANGEL. OK. Then you will send those names to me?

Mr. GREENSPAN. Yes, sir.

Chairman RANGEL. Is there anything that any of the members would like to add before I call the next panel? Is there a serious concern about the loss of tax exemption with the not-for-profit hospitals?

Mr. COOPER. My fear is that if the President's plan passes we are going to see the Wal-Martization of health care. I will go back to Wal-Mart for a second. When Wal-Mart comes into a community, they, at least one theory says, they lower their prices, they drive everybody else out of business, and then as soon as everybody else is out of business they raise their prices, and there is no more competition.

Under the President's plan, what I think is going to happen is we are going to see large conglomerates of for-profit chains like Columbia HCA coming into communities, driving not-for-profits out of business. We saw that in Florida already. As soon as they drive competition out of business in the name of competition, then what we will see left is a few large chains running the health care system of this country, and there won't be any competition in spite of what Congressman Cooper and others would like to think we are going to have.

Chairman RANGEL. OK. I will probably, after I reread your testimony, send some questions and ask you to respond in writing, OK? Thank you.

The next to the last panel is Tom Salmon, associate director, Mental Health Management of America; Ken Raske, an old friend of the Committee's, Greater New York Hospital Association; and Marc Wolfert, vice president, Health Insurance Plan; my old friend in mourning, Stanley Hill. Where is Stanley? Still holding up, my friend? International vice president, executive director of District 37; and, of course, Larry McAndrews, president and CEO of the National Association of Children's Hospitals and Related Institutions. We will start off with Tom Salmon, the director of Boston's Mental Health Management.

**STATEMENT OF THOMAS P. SALMON, ASSOCIATE DIRECTOR,
MENTAL HEALTH MANAGEMENT OF AMERICA, BOSTON, MASS.**

Mr. SALMON. Good afternoon, Mr. Rangel. I would like to summarize my testimony rather than read all of it to you, hopefully leave some time for questions.

Chairman RANGEL. By unanimous consent, there are no objections. All of the panel's testimony will be entered into the record. You may highlight it.

Mr. SALMON. I come here I think with some good news, and that is that in Massachusetts we have had some positive experience in providing health care to an impoverished population, the Medicaid population of Massachusetts, over the last 2 years through a HCFA waiver that permitted introducing managed care to the Medicaid program in Massachusetts.

I would like to comment particularly on the mental health substance abuse carve-out of that program. I think that may be to your interest and it also is the area that I am most familiar with. Basically in 1990, Massachusetts Medicaid was looking at a runaway cost program. The projections for the mental health substance abuse expenditures, at that time they were about \$120 million per year. The projection for State fiscal year 1994 was that they would reach over \$200 million per year. That, along with similar but somewhat smaller inflationary and runaway costs in the medical-surgical portion of the Medicaid program in Massachusetts led to requesting and receiving a HCFA waiver and introducing in a system statewide way managed care.

Mental Health Management of America/First Mental Health received the mental health substance abuse managed care contract, and in January 1992 began to phase in a managed care approach. I have worked, and this is a bit of an aside, I have worked in the public sector. I was Assistant Commissioner of Public Health in

Massachusetts and, in fact, director of the State drug authority for a number of years, and I say that because I think I have seen both sides, both the public side and I have also seen the provider side.

I have run a private drug and alcohol treatment program for a number of years, and I had very mixed feelings about managed care. I think what this country saw of a lot of managed care was its beginnings which were partial implementations of managed care. Managed care in its best sense, and in my testimony I outline what I think are its basic principles, does indeed concern itself with access to services with comprehensive services, with assuring continuity of care, with quality of care, and also with affordability, all I think concerns that the country as a whole now shares.

We believe that we have managed over the last 2 years to put a restraint on the runaway costs of mental health substance abuse services for Medicaid recipients, but have also assured their access to care. We know that we have served a similar number of recipients, unduplicated recipients as was served under the old Medicaid plan, which was in effect a fee-for-service indemnity plan with no real management.

We have achieved significant savings in doing that, and we believe we are on the way to dealing with some of the issues that you raised this morning, Congressman, which, I think, are issues that trouble us all, and that is how does the acute health care sector effectively interact with the longer term rehabilitative components of the treatment, the mental health and substance abuse treatment systems that exist in most States.

We have done that by negotiating formal agreements with the State agencies about whose responsibilities begin when, and agreeing and I think making real the operating principle that the client doesn't sit somewhere waiting while different entities decide whose responsibility the care is.

We have seen that acute care is certainly essential for a portion of this population. We have also seen that they can be served effectively in less costly settings, and in particular in substance abuse we have found that the majority of patients can be safely and effectively detoxed in facilities outside of hospitals.

That has produced savings that have permitted adding on some other services that were not available under the Medicaid coverage, so I think the good news is that it is possible to go into a scenario where there are runaway costs and contain those costs and continue to provide good quality care and successful care, but the underlying note there is that there are other funding streams that are still essential to continuing good, long-term care, care for the chronically mentally ill, and the chronic substance abuser.

The dollars that stream through the State departments of mental health and in Massachusetts public health and the substance abuse agency continue to provide the long-term residential programs that some, and I stress the some, some portion of the mentally ill and substance-abusing population require. I think it is important in looking at universal health insurance that we not overexpect that what is in effect an acute health care insurance policy substitute for or replace these other essential services.

Thank you, Mr. Congressman.

[The prepared statement and attachments follow:]

**TESTIMONY OF THOMAS P. SALMON
MENTAL HEALTH MANAGEMENT OF AMERICA, BOSTON, MASSACHUSETTS**

BACKGROUND

In 1991 the Commonwealth of Massachusetts faced the crisis of a runaway Medicaid budget. With a cost growth curve approaching twenty percent a year political consensus emerged on the need to constrain this "budget buster". Rather than cutback on the benefit package or restrict eligibility the Department of Public Welfare sought and received approval for a two year Primary Care Clinicians and Mental Health/Substance Abuse program waiver. The Health Care Financing Administration authorized a program waiver under section 1915(b)(1) and (4) of the Social Security Act. This approval provides for waiver of section 1902(a)(10), Comparability of Services, and 1902(a)(23), Freedom of Choice. For the purpose of this testimony the relevant effect of the HCFA decision was its authorization of the Division of Medical Assistance to contract with a prepaid health plan to serve as the State's agent for the delivery of mental health and substance abuse services to eligible Medicaid clients.

MHMA/First Mental Health, a Nashville based mental health/substance abuse managed care company specializing in services for Medicaid and Medicare programs, successfully responded to the ensuing request for proposals. In keeping with its own roots in the community mental health model of service delivery, MHMA shared a belief with the Division of Medical Assistance that excessive costs for mental health and substance abuse services result principally from utilization of the wrong treatment settings for inappropriately long durations. Therefore, if a managed care approach can help patients have access to the right type of care - in terms of location, intensity and duration - high quality and cost-effective care is simultaneously ensured.

Over the calendar year 1992, MHMA put into a place a statewide network of acute, hospital level psychiatric and substance abuse units, residential programs for child/adolescent psychiatric and substance treatment and for adult, medically monitored detoxification and short term, intensive rehabilitation treatment. The existing Medicaid approved outpatient provider system was maintained. A program of clinical utilization review for inpatient services began and provider billing processing and reimbursement was assumed by MHMA. By January 1993, a fully capitated, at-risk, mental health/substance abuse managed care program for eligible Medicaid recipients was in full operation in Massachusetts.

For the remainder of this testimony, in response to the interests of the sub-committee, I will focus on the area of substance abuse treatment. Much of the general background information is applicable, although it is important to note that in its development and operation of the Mental Health/Substance Abuse Program (MH/SAP) MHMA recognizes that substance abuse treatment has its own developmental history, its own professional entities and its own research literature. It is more than a sub-specialty within the field of mental health. To assure that we have in-house expertise MHMA employs a senior staff specialist in substance abuse treatment. This person works on network and program development, on program quality monitoring and improvement, on the development and review of clinical standards and procedures and with the state alcohol and drug treatment agency to coordinate resource planning. He is a Ph.D. psychologist who, coincidentally, is the newly appointed chair of the American Society of Addiction Medicine's Committee on Managed Care. In addition, the clinical utilization review for substance abuse treatment is done by master level nurses and clinicians with at least eight years' experience in substance abuse treatment.

In building the MHMA substance abuse treatment network in Massachusetts, the principles of quality managed care and the essential tenets of the substance abuse treatment field provide the core guidelines. We believe that substance abuse is a chronic, progressive and potentially fatal disease but that it is treatable with the right intensity and level of treatment over time. We further believe that the quality principles of managed care lend themselves particularly well to the effective treatment of substance abuse. As applied to the field of substance abuse treatment, managed care principles require services to be:

ACCESSIBLE It is essential that there be timely treatment for the substance abuser. This translates to services which are geographically and culturally available when the patient seeks them. MHMA has developed a statewide network of specialty substance abuse treatment services and monitors them for ready accessibility. Every effort is made to eliminate administrative barriers to access. For example, emergency admissions are reviewed retrospectively, Level III detour admissions are certified 48 hours after admission and every recipient has eight outpatient visits to each and any outpatient provider before any utilization review occurs. Network management also inventories and assists with enhancing programs' ethnic, cultural and linguistic diversity.

COMPREHENSIVE A quality network of services will include all the levels of care needed for the acute and ambulatory treatment of substance abuse. The MHMA network for substance abuse treatment in Massachusetts includes:

Acute Hospital Units (Level IV) for medically or psychiatrically complicated detoxification;

Freestanding Residential Detoxification Programs (Level III) for medically monitored treatment of drug and/or alcohol withdrawal;

Acupuncture Detoxification Treatment Services;

Acute Residential Treatment Facilities for short term, intensive, rehabilitative services;

Structured Outpatient Addiction Programs for an ambulatory, short term, intensive, rehabilitative service;

Individual, group and family counseling by psychiatrists or in outpatient treatment centers; and

Methadone Maintenance treatment with counseling services. (See Exhibit I)

CONTINUOUS Through clinical utilization review of residential services, with a particular focus on aftercare planning, as well as through program practice pattern profiles and reviews of extended outpatient treatment authorizations; MHMA works with providers of care to develop plans that assist recipients in moving to and staying for enough time with the needed level of treatment intervention. It is our conviction that this sustained focus on the treatment history and current treatment needs of the recipient enable us to assist network providers in delivering the right care at the right time to the right recipient.

QUALITY By its own corporate commitment, reinforced by the contractual requirements of the Commonwealth of Massachusetts, MHMA operates its managed care program within the tenets of Total Quality Management. In keeping with this, we have developed an information and reporting system that gives a first time capacity to produce timely information on client treatment needs and on program performance. To provide a structural context for these reports and measures there are detailed program specifications and standards. In consultation with clinical providers, protocols have been developed which describe parameters of treatment for DMS III diagnostic categories

and reflect current best practice. Regular surveys provide information for analysis and action in order to remain responsive to clients' levels of satisfaction with the care given and providers' satisfaction with MHMA operations and management. In the next two years the emphasis will be on identifying and collecting outcome measures which should help shape the system in an information driven manner to better serve recipients. (See Exhibit II)

MHMA/First Mental Health is convinced that managed care done well produces quality care and that much of the philosophy and practice of the community mental health field are consistent with the delivery of truly cost-effective service, i.e. service which achieves the best outcome for the resource invested. What this means is you can get the same or better results for less cost using the principles and tools of managed care. The program in Massachusetts has been successful to date because it is based on a Medicaid system that had an ample benefit package albeit without any structural or operational constraints on excess and without any capacity to redirect resources to more effective interventions. MHMA's managed care experience has brought needed cost restraint and the capacity to quickly develop and put in operation services which are more cost-effective, e.g. the Structured Outpatient Addiction Programs and the shift from Level IV inpatient days to Level III.

(See Exhibit III)

The achievement of quality care at a contained cost is a major achievement. It requires the flexibility which a managed care approach can bring to the service delivery configuration. Ideally, this approach is financed by capitation; there is a clear and specific definition of the benefit package; there is incentive to provide innovative and alternative levels and types of treatment; and there is provision for maximum transferability of dollars across types of treatment. Finally, there must be a capacity to collect and report data in a timely manner on both recipient patterns of care and program performance with structural and organizational mechanisms to translate the data into information for action. If all of these factors are present, then the kind of iteration and ongoing evaluation can occur and make possible an increasingly effective network of treatment services of the type envisioned by David Lewis, M.D. in his Broadening the Base of Treatment for Alcohol Problems. MHMA believes that the substance abuse treatment field can advance its practice knowledge base in collaboration with managed care organizations which are committed to quality care through quality managed care.

It is always more enjoyable to talk about the positive possibilities of new and innovative efforts like the Mental Health/Substance Abuse Program for Massachusetts Medicaid recipients. However, it is also important to note the limitations. Medicaid in Massachusetts provides public funding for recipients who are eligible and need acute healthcare insurance. The benefit package which MHMA/First Mental Health manages provides for acute inpatient and for ambulatory care. As such, it does not provide the financing necessary to address the many other problems and service needs of recipients who are substance abusers. Such services as recovery homes, half-way houses and other longer term residential treatment services receive funding from the Department of Public Health's Bureau of Substance Abuse Services. These services provide an essential place on the full continuum of care. MHMA recognizes this and has both a formal written agreement with the Department of Public Health as well as regular meetings of staff to improve the coordination of service delivery. In any planning at the federal level around the possible reallocation of monies to fund a national healthcare proposal, it is vitally important that the substance abuse benefit (assuming that it remains essentially what it is now, an acute healthcare benefit) not be viewed as duplicative of the longer term and more chronic care oriented services currently funded under other federal programs such as the block grant and the Omnibus Drug Treatment Act. Good acute substance abuse services can go a long way toward alleviating the addiction problem in this country. But, acute services alone are not sufficient.

MHMA/First Mental Health has worked successfully to date with the Massachusetts Division of Medical Assistance and with a network of outstanding substance abuse treatment providers to deliver quality addiction treatment. There remains much to do. The unaddressed treatment needs of the substance abuser with additional major psychiatric illness continue to challenge the psychiatric and substance abuse treatment systems. MHMA has made the start-up of residential and ambulatory treatment capacity for the dual diagnosed a priority for this next year. Our collaborative relationships with providers in both mental health and substance abuse treatment will help achieve this goal. We will also be implementing innovative models to better case manage the chronic substance abuser, i.e. assist the recipient in using more effectively the available treatment and/or developing additional interventions. In all of this, we believe that managed care can maximize effective resource utilization but must, with the rest of the substance abuse treatment field, look to government for the additional funding to meet the housing, educational/vocational rehabilitation and short-term income maintenance needs of those struggling to recover from addiction.

EXHIBIT I

MHMA NETWORK OF TREATMENT SERVICES
September 30, 1993

Inpatient Hospitals

Adult Psychiatric Units	34
Child/Adolescent Psychiatric Units	15
Addiction Treatment Units (Level IV)	8

Acute Residential Treatment

Adult Substance Abuse	17
Adolescent Substance Abuse	4
Adolescent Mental Health	7
Child/Adolescent Mental Health	17

Residential Detoxification Program (Level III) 29

Partial Hospitalization Programs

Adult Psychiatric	27
Child/Adolescent Psychiatric	16
Mobile Crisis Teams and Stabilization Beds	30
Family Stabilization Teams	13
Structured Outpatient Addiction Programs	16
Adult Psychiatric Day Treatment	42

Outpatient Services

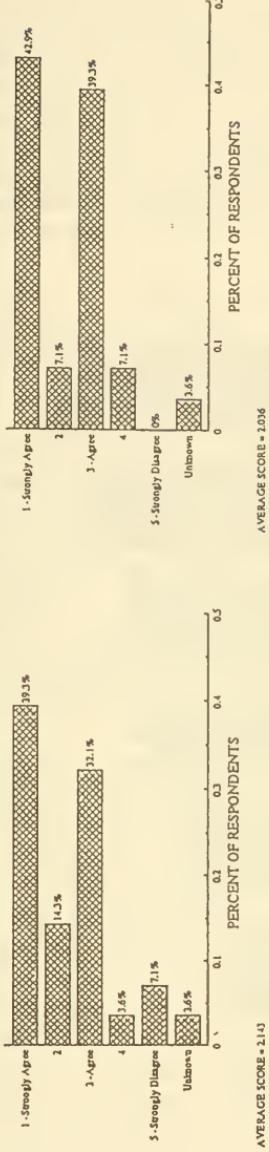
Psychiatrists	660
Psychologists	520
Mental Health Clinics	135
Substance Abuse Clinics	80
Methadone Treatment	12
Hospital Clinics	57

MHMA SNAPSHOT CLIENT SATISFACTION SURVEY

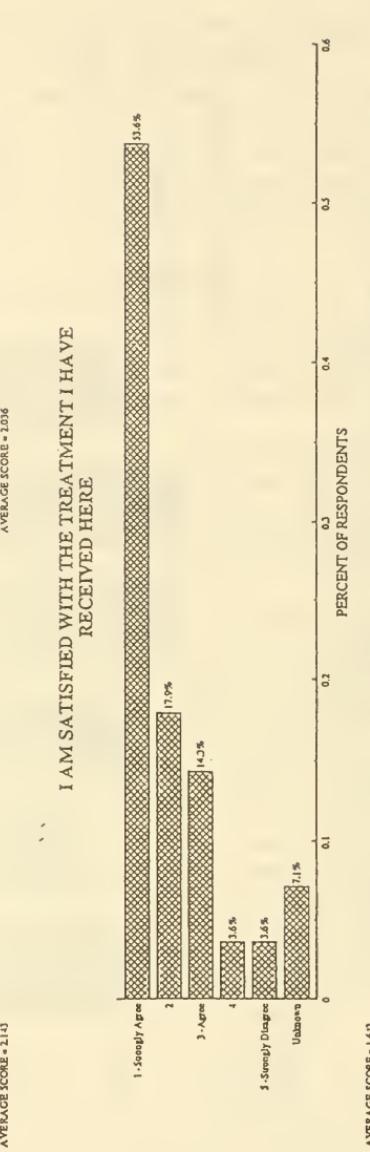
LEVEL III DETOXIFICATION PROVIDERS ONLY

I FEEL BETTER ABOUT MYSELF AND MY FUTURE THAN
WHEN I BEGAN THIS TREATMENT

I FEEL MORE ABLE TO HANDLE MY DAY TO DAY
RESPONSIBILITIES NOW THAN WHEN I BEGAN
TREATMENT

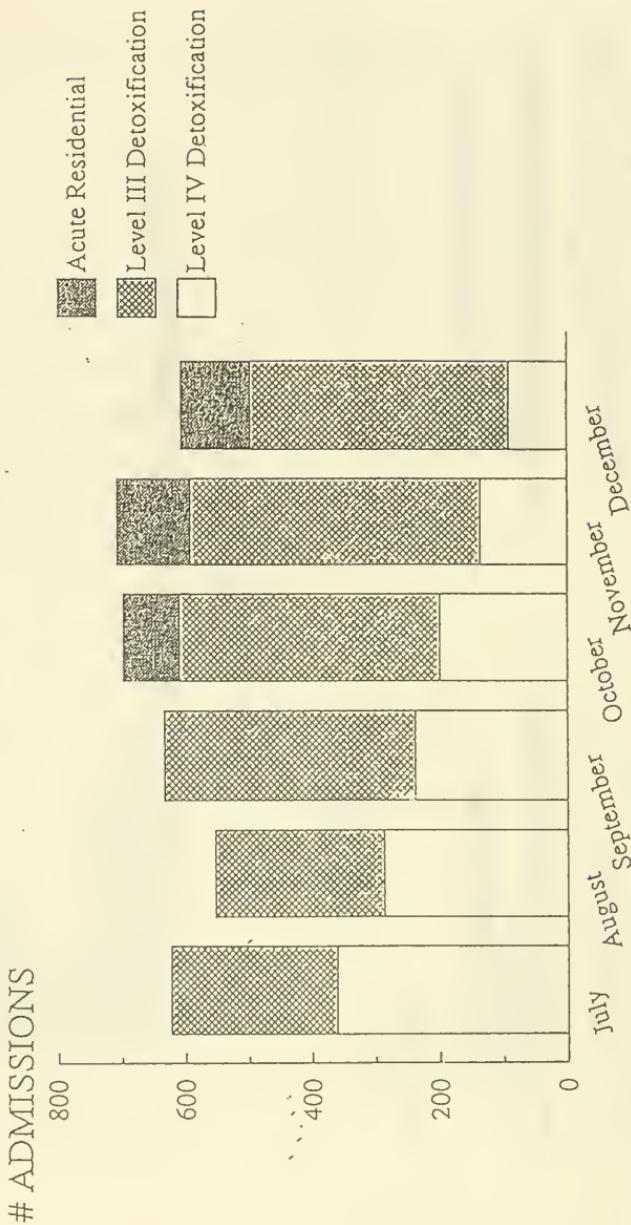


I AM SATISFIED WITH THE TREATMENT I HAVE
RECEIVED HERE



SUBSTANCE ABUSE ADMISSIONS

JULY, 1992 - DECEMBER, 1992



This data is claims based

Chairman RANGEL. Mr. Raske.

STATEMENT OF KENNETH E. RASKE, PRESIDENT, GREATER NEW YORK HOSPITAL ASSOCIATION, NEW YORK, N.Y.

Mr. RASKE. Thank you, Mr. Chairman. It is always a pleasure to testify before you, Mr. Rangel, because of the prominence that you hold in the hearts of all New Yorkers as well as in the Congress itself. My statement will be relatively short. It is a summary, of course, of the submitted testimony, and the appendix which is a study which was accomplished by the Greater New York Hospital Association.

Right to the point, we want health care reform to work in New York. We want it to work for New York. We want it to work with the New York government as well as with the New York hospitals. So what I have to say today is really nothing more than constructive criticism of what we see early on in this plan, intended to help shape the design sometime in the future.

We extend to the Members of Congress, to yourself especially, but to your colleagues as well, all the assistance of New York hospitals in trying to come up with a workable plan. Our early on impressions are, of course, that it is a good start, but there are some difficulties on the financing side. I wish to point some of them out to you this afternoon.

Specifically when we take a look at how this plan works in terms of the New York City hospital system, and I am speaking, Congressman Rangel, both in terms of the Health and Hospitals Corporation as we know is the big City system, then the small city with not a capital C in terms of the voluntaries, it appears to us early on that there is more money withdrawn from the system through the Medicare and Medicaid cuts than is restored through the provision of universal coverage.

On the other hand, with respect to the increased coverage, and the benefits that extend to obviously the population being covered, but also to the institutions who no longer will have bad debt and charity care. The numbers at this point look to be about \$4 billion distance—\$8 billion in, \$12 billion out, \$4 billion net negative. We are trying to refine our model and work with the administration to make sure that what we are saying is accurate, is meaningful, and is right to the point.

It is not our sense to create a false sense of insecurity. That is not what we do for a living. Instead we want to be precise so that we know what the diagnosis is so we can come with a cure. No matter what rendition, whether we add cost reduction efforts in terms of caps on payroll, that might be beneficial to hospitals in terms of their own payments or what have you.

It still looks like a \$4 billion gap. Therefore, when we take a look at what the cuts are, we are not surprised that you are going to find the kind of impact that we concluded.

Namely, if you take a look at medical education, which is a major component of the Medicare cuts, we are at ground zero for a lot of medical education in the United States. We train 15 percent of all residents. Many of them provide services in terms of patient care if not most of them. So as a result, when we see serious medical education cuts which are being proposed to help finance this par-

ticular plan, you conclude that in New York you get a disproportionate impact just by definition of the percentages.

If those percentages were changed, if those cuts were flattened out, if they did a number of other things, then a lot of the impact would be dissipated. It is our sense that what this plan needs to do is to push back on a lot of those Medicare and Medicaid cuts restoring that with some alternative revenue source and in the process of doing that the promise of health care reform for all New Yorkers will be fulfilled, and that is the message that I bring to you today.

With respect to the subject at hand, specifically the question of tax exemption, you were on target when you were asking the gentleman from the Hospital Association of New York State, if you can't differentiate between a hospital with not-for-profit services and for-profit services, then there ought not be any difference.

Not-for-profit hospitals must demonstrate that they are doing something to deserve that status and therein lies the issue of defining that mission, and the service plans that are called for in the Health Care Reform Act is one way of doing that.

Thank you sir.

[The prepared statement follows:]

GNYHA

GREATER NEW YORK HOSPITAL ASSOCIATION

555 West 37th Street / New York, N.Y. 10019 / (212) 246-7100 / Fax (212) 262-6350

Kenneth E. Raske, President

**TESTIMONY
OF THE
GREATER NEW YORK HOSPITAL ASSOCIATION
BEFORE THE
SUBCOMMITTEE ON SELECT REVENUE MEASURES
ON
THE IMPACT OF CERTAIN TAX-RELATED ASPECTS
OF THE ADMINISTRATION'S
HEALTH CARE REFORM PROPOSAL ON
RESIDENTS OF INNER-CITY AND OTHER DISTRESSED NEIGHBORHOODS
NOVEMBER 9, 1993**

Good morning, Chairman Rangel, members of the Subcommittee. My name is Kenneth E. Raske and I am President of Greater New York Hospital Association (GNYHA), which represents 164 hospitals and nursing homes in New York City and its surrounding communities. I am delighted to note that, effective last January, the 16 hospitals and nursing homes that comprise the New York City Health and Hospitals Corporation became GNYHA member institutions. Among our membership are six world-renowned academic medical centers, municipal hospitals caring for the City's most vulnerable populations, financially distressed non-profit hospitals serving large numbers of New York's poorest residents, and a large number of teaching hospitals committed to training the nation's physicians. Therefore, all of GNYHA's members will be profoundly impacted by the health care reform legislation ultimately enacted, and, for that reason, I greatly appreciate this opportunity to testify on their behalf.

In my statement, I will address several topics germane to today's discussion: I will profile GNYHA's membership because, for a variety of reasons, these hospitals are not prepared for health reform to the same extent as are many of their counterparts nationally; I will provide the results of GNYHA's preliminary analysis assessing the revenue impact of the Administration's plan on New York City hospitals; I will discuss how the health reform plan, by itself, does not address many of the broader social problems that have long been plaguing urban and inner-city hospitals or, as the notice for this hearing appropriately pointed out, "the intricate interrelationship of the problems of economic development, education, health, substance abuse and violence" in inner-cities; and, finally, I will address why, at least in New York, I believe that the tax-exempt status of non-profit hospitals ought not be jeopardized by the enactment of Federal health care reform.

PROFILE OF GNYHA'S MEMBERSHIP

As the debate on health care reform begins in earnest, GNYHA believes that it is important to understand the unique environment that characterizes the health care delivery system in the New York City area. Outlined below are a number of factors that we believe need to be seriously considered when evaluating the effectiveness of any health care reform proposal for improving the health of New York City's communities and providers.

- **New York Hospitals Cannot Shift Costs:** All inpatient hospital rates charged to non-Medicare payers or insurers in New York are set by State government; therefore, unlike hospitals in other states, New York hospitals cannot make up cuts in Medicare and Medicaid payment rates through increases in rates charged to other payers, i.e., through so-called cost-shifting. This situation makes supplementary reimbursement streams such as disproportionate share (DSH) adjustments and graduate medical education (GME) funds critical to the viability of many New York facilities.
- **New York Hospitals Train the Nation's Physicians:** Fifteen percent of all residents trained nationwide are trained in New York City hospital residency programs. Due to New York's rate-setting system and the inability of New York hospitals to shift the costs of care for the uninsured to other payers, New York hospitals — public and private — rely heavily on graduate medical education funding to pay residents, including specialty residents, who provide

much of the care for the poor in the City. Therefore, GME funding pays for more than medical training in New York: it pays for services.

- **New York Hospitals Battle Particularly Severe Epidemics:** Twenty percent of all AIDS cases nationwide are treated in New York City. New York City has more cases of tuberculosis than Atlanta, Boston, Chicago, Houston, Los Angeles, Miami and San Francisco combined. In addition, New York has more cases of substance abuse than any other city in the nation. As a result, New York hospitals treat sicker and costlier patients than hospitals elsewhere and, therefore, rely heavily on Medicare disproportionate share (DSH) funds to help cover these costs.
- **New York Hospitals are Undercapitalized:** Due to both New York's strict certificate of need program as well as its restrictive rate-setting system, New York hospitals have had difficulty making necessary capital improvements and building the cash reserves necessary to secure capital financing in the future. Similarly, New York hospitals will have difficulty finding the capital necessary to create the networks envisioned under the Administration's plan. Adequate Medicare capital financing, access to FHA-backed loans, and new funds for network development will be crucial to help New York health care providers improve the health care infrastructure and prepare for reform.

IMPACT OF PRESIDENT'S HEALTH CARE REFORM PLAN ON NEW YORK CITY AREA PROVIDERS

GNYHA does not want to diminish the importance of achieving universal coverage, and will advocate strongly to see it accomplished, but we are terribly concerned with the manner in which the Administration's plan would be financed, namely, through deep cuts in the Medicare and Medicaid programs designed to assist vulnerable populations and the providers who serve them. GNYHA's preliminary analysis indicates that if the plan were financed as currently proposed, the hospitals in New York City would experience net revenue reductions of such magnitude that many would not be able to sustain their current level of operations. The hospitals most at risk appear to be those serving high concentrations of patients whose health insurance coverage is publicly financed through the Medicare and Medicaid programs. This finding would likely hold for other large urban and inner-city communities as well.

The theory underlying the health reform proposal is that incremental revenue derived from the provision of health insurance coverage for the currently uninsured will offset Medicare and Medicaid payment reductions, such that hospitals and other health care providers will be held harmless from major funding dislocations caused by shifts in the financing of health care coverage under health reform. While this may or may not be true on a nationwide basis, it is clearly not the case in certain regions of the country, particularly large urban centers that, heretofore, have attempted to ensure access to health care services for all who are in need.

Indeed, hospitals in New York City might expect to realize \$8 billion in new revenue from 1996 through 2000 from the provision of universal health insurance coverage. Yet, this would leave a revenue gap of \$4 billion, since the value of the expected Medicaid and Medicare payment reductions is about \$12 billion.

A five-year loss of \$4 billion, or \$800 million on an average annual basis, representing over 4% of gross revenues, could not be sustained by the hospitals in New York City, as they are currently operating with virtually no financial cushion. In many other areas of the country, a revenue contraction of 4% would squeeze a hospital's profit margin, such that a loss of this magnitude would inhibit the institution's ability to invest in capital projects and innovative programs, but it would not put the hospital out of business. New York's voluntary hospitals, on the other hand, are operating essentially at break even, such that a 4% revenue contraction would force the closure of certain programs or institutions. When the financial results of the private and public hospitals are combined, the aggregate bottom-line margin for the City's hospitals in 1992 was -1.1%.

Mr. Chairman, I have provided you with a complete copy of GNYHA's preliminary analysis and have attached a summary table to this statement.

HEALTH REFORM DOES NOT ELIMINATE THE NEED FOR UNCOMPENSATED CARE ADJUSTMENTS

The problems that plague American society are particularly pronounced in urban and inner-city areas -- violence, substance abuse, homelessness and other public health epidemic such as AIDS and TB that are raging unabated. Consequently, urban and inner-city hospitals are increasingly relied upon to play a role and provide services that exceed the traditional understanding of health care provider and health care services.

It is for precisely this reason that the Administration's proposal to eliminate Medicaid disproportionate share funding is so distressing for urban hospitals. The Medicaid DSH program is more than a subsidy for care to the uninsured: It recognizes the additional costs associated with caring for the poor and underserved who are often sicker and whose needs include a broad array of social services not accounted for in a basic benefit package, such as transportation, clothing, security and housing. The Administration's plan acknowledges these added costs both in its proposal for risk adjusting health premiums and with the establishment of a "vulnerable populations" pool, yet, GNYHA is concerned that these programs may not go far enough to address the additional costs associated with these patients. With respect to risk adjustments, it is difficult to conceive of a method that could adequately account for the more serious health problems of urban America. For instance, a mere 10% of Americans account for more than 70% of health outlays, while wholly 50% account for less than 3%. Moreover, the vulnerable populations pool is proposed to be funded at a capped level of \$800 million annually nationwide which is roughly equal to the value of Medicaid DSH payments in New York City alone.

The Administration's plan recognizes the extraordinary role played by certain of these providers serving underserved areas through its special designation for "Essential Community Providers." To be certified as "essential," a hospital must be located in an area designated as a health professional shortage area or provide a "substantial amount of health services ... to a medically underserved population." The Health Security Act would require health plans to contract with "essential community providers" during a five-year transition period. GNYHA supports this provision and urges that essential providers be defined broadly enough to capture those voluntary, non-profit and public-sector providers alike that have demonstrated a commitment to caring for underserved communities.

Finally, GNYHA cannot emphasize strongly enough that many of the problems that both the residents as well as the providers in this City experience are the result of social problems that will not be alleviated with the provision of health care coverage. This nation needs health care reform, but it likewise needs thoughtful solutions to the larger problems of inner-city communities mentioned before: violence, poverty, substance abuse, and the like.

TAX TREATMENT OF NON-PROFIT HEALTH CARE PROVIDERS

The Administration's health plan would require hospitals and other non-profit health care organizations to assess annually the health care needs of their communities and to develop a plan to meet those needs in cooperation with community representatives in order to qualify as charitable organizations and, therefore, remain tax-exempt. Hospitals in New York have been held to a similar standard since 1991, when State legislation was enacted requiring voluntary not-for-profit hospitals to develop community service plans and to report annually on their efforts to meet community need. The community service plan requirement in New York has several components, including: making publicly available an institution's mission statement; soliciting community involvement; determining and meeting community needs; and demonstrating an institution's financial commitment to its community. Therefore, this particular provision of the Administration's health plan does not present a problem or challenge for GNYHA's members.

Nevertheless, I remain concerned with the notion that health care reform in and of itself will alleviate the financial and other burdens that have gradually become the responsibility of urban and inner-city hospitals. I have already described the impact that violence, homelessness, substance abuse and other public health epidemics have had on GNYHA's members and similarly situated institutions nationwide. The provision of a package of basic health care benefits will not fix this broad array of social problems that have flowed to urban hospitals. Therefore, I believe that it will be quite a long time before the tax-exempt status of these not-for-profit institutions may be legitimately challenged.

CONCLUSION

Congressman Rangel and members of the Subcommittee, I greatly appreciate today's opportunity to present GNYHA's early views of the Administration's proposal for health reform. To reiterate, while we strongly support the goals of reform, particularly the provision of universal coverage, we remain concerned with the financing strategy presented to date as it appears to put New York City area providers at significant risk. GNYHA looks forward to working constructively with you and your colleagues in the coming months in crafting a reform plan that improves the lives and health of all Americans, and does not disadvantage urban and inner-city communities.

Chairman RANGEL. Mr. Wolfert.

**STATEMENT OF MARC S. WOLFERT, VICE PRESIDENT,
GOVERNMENT ASSISTED PROGRAMS, HEALTH INSURANCE
PLAN OF GREATER NEW YORK**

Mr. WOLFERT. Thank you, Mr. Chairman.

I am Marc Wolfert, vice president of Government Assisted Programs for the Health Insurance Plan of Greater New York, a not-for-profit, prepaid group practice model HMO operating in New York, New Jersey, and Florida. I am pleased to testify about HIP's unique experience providing integrated health care to inner-city, at-risk populations.

We also appreciate this opportunity to address some of the important provisions in President Clinton's Health Security Act.

First let me provide the subcommittee with a brief history of the HIP system. HIP was created during a time of health care crisis in New York City nearly 50 years ago as a not-for-profit organization with a mission to provide adequate, affordable health care to diverse populations.

Today the HIP system serves nearly 1.2 million members. We have found our prepaid group model system to be highly effective. HIP has served Medicaid recipients since the inception of the Medicaid program in 1966. Voluntary Medicaid enrollment now exceeds 71,000 members.

Medicaid recipients and special populations, many of whom reside in inner cities where social factors driven by poverty result in poor transportation, poor housing, inadequate schooling and low educational achievement, drug abuse, illegitimacy and the disturbing results associated with violence, present special challenges to a health plan.

HIP has found one of the best ways to combat this myriad of social and environmental factors is to insist on a one-class system of health care that doesn't differentiate between individuals based on their ability to pay. For example, HIP centers in federally designated, medically underserved communities in New York, such as the Manhattan West Center at Amsterdam Avenue and 155th Street in Harlem, have a substantial mix of Medicaid as well as commercial HIP members.

HIP salutes the core principles on which the President has built his proposal for health system reform. Specifically, the administration should be recognized for including in the Health Security Act provisions which are responsive to the pressing health needs of inner city populations, including a comprehensive benefit package, provisions which would protect community health against communicable diseases, grants for core public health functions, cooperative activities to reduce violence levels in communities, et cetera.

There are three major features of the Health Security Act that concern HIP based on our preliminary analysis of this far-reaching legislation. First, the act includes several substantial surcharges to health plan premiums, costs which are not now built into our price structure.

Examples of these are included in my written testimony. Conservatively these would total between 7 and 10 percent of premium

increases, while the national median HMO surplus margin is approximately 3.4 percent.

These assessments, coupled with the premium caps, penalize already efficient HMOs that have kept administrative costs under 8 percent and whose surplus funds are used to improve services to members.

Second, we support the idea conceptualized in the alliance system of an integrated regulatory apparatus. However, our experience operating in three States causes us concern that the alliances would likely operate as an additional layer of bureaucracy on top of the State's current regulatory structures.

Third, the alliance boundaries will be drawn by States. As a November 5 article in the New York Times titled "Conflict is Seen Between Regions in Health Plan" points out, separating Long Island into one alliance and the five boroughs of New York City into another will drive up rates for inner-city residents.

Presently, HIP community rates that entire geographic area of New York City, Long Island and Westchester area, resulting in affordable premiums for all.

Finally, there are significant tax issues which must be addressed.

First, the act requires all health plans to offer a point-of-service product in addition to our HMO activity, the only product we now offer. This could have far-reaching implications for the 501(c)(3) status of health plans.

A second tax-related concern which is not addressed in the Health Security Act relates to access to capital for tax-exempt organizations such as HIP. Mr. Chairman, you have been a strong supporter of repealing the \$150 million cap on tax-exempt debt which is imposed on organizations exempt from paying taxes under 501(c)(3) of the code. This cap is a significant barrier to our ability to expand and renovate our facilities and equipment.

We have noted in this testimony only a few of the structural and operational aspects which concern us and which may result in conflicting goals that will consume health dollars better used to meet the needs of our enrollees.

We look forward to working with you, Mr. Chairman, and with this committee to correct some of the concerns noted above and to help shape the final legislation.

Thank you.

Chairman RANGEL. Thank you.

[The prepared statement and attachments follow:]

Written Statement**prepared by****Marc Wolfert****Vice-President, Government Assisted Programs
Health Insurance Plan of Greater New York****before the****Subcommittee on Select Revenue Measures****Committee on Ways and Means****U.S. House of Representatives****Washington, DC****Tuesday, November 9, 1993**

My name is Marc Wolfert and I am Vice-President for Government Assisted Programs for the Health Insurance Plan of Greater New York, a not-for-profit, prepaid group practice model health maintenance organization operating in New York, New Jersey and southeast Florida.

I am pleased to present testimony today that outlines HIP's unique experience providing integrated, comprehensive health care to inner city residents and at-risk populations.

We also appreciate this opportunity to address some of the many important provisions in President Clinton's Health Security Act which could fundamentally restructure the American health care system.

BACKGROUND

First, let me provide the subcommittee with a brief history of the HIP system.

HIP was created during a time of health care crisis in New York City nearly 50 years ago, as a not-for-profit organization with a mission to provide quality, affordable health care to diverse populations.

From its beginning, HIP has offered health care coverage through a community-rating system. This rating system treats everyone as part of the same community -- young, old, healthy, sick. It allows varied groups to pay the same price for a wide range of benefits based on the anticipated cost of care for everyone. HIP views community rating as the best way to spread risk while assuring access to health care for all people. We strongly support the Clinton plan's reliance on community rating.

Today, the HIP system serves nearly 1.2 million members throughout the New York City metropolitan area, New Jersey and southeast Florida. HIP members are employees of groups as diverse as Fortune 500 companies, federal, state and city governments, middle size and small businesses. Others receive benefits through the Medicare and Medicaid programs, and some enroll directly in a special plan for uninsured individuals. HIP also offers coverage to a number of special populations including uninsured children and small businesses enrolled in state subsidized programs in New York. In New Jersey, in addition to enrolling large and small employer groups, and Medicare and Medicaid beneficiaries, we are enrolling uninsured individuals in compliance with that state's recently enacted health insurance reform plan. In Florida HIP participates in the newly established small employer plan. Shortly, HIP Network of Florida will enter into a Medicaid contract.

In New York and New Jersey, HIP's prepaid group practice system relies on affiliations with groups of physicians devoted on a full-time basis to the care of HIP members. Affiliated physicians practice in medical centers with colleagues from virtually every specialty. At present, HIP-New York contracts with six independent medical groups

for the services of 618 primary care physicians and 297 specialty physicians. HIP members have access to over 800 consultant specialists on a referral basis. Affiliated physicians care for patients in HIP-owned or leased medical centers.

We have found our prepaid group model system to be highly effective for a variety of reasons. The emphasis on preventive care helps providers detect illness at its initial stages, making early intervention possible and helping to avoid more costly care for advanced illness. Since affiliated physicians devote themselves on a full-time basis to the medical groups, they have no financial incentive to provide unnecessary services. At the same time, affiliated physicians are free to order any diagnostic tests they believe are appropriate.

The Congressional Budget Office has recognized the efficiencies of group and staff model HMOs.

Fully integrated HMOs with their own delivery systems are the forms of managed care for which demonstrated cost savings are the greatest. CBO has estimated that staff- and group-model HMOs reduce personal health expenditures by 15 percent from their levels under traditional private health insurance with typical coinsurance. ("Estimates of Health Care Proposals from the 102nd Congress," Congressional Budget Office, July 1993.)

Further, the CBO has found:

Moving people from fee-for-service medicine into staff- and group model HMOs would reduce health care spending. If everyone with health insurance were to enroll in these HMOs, national health expenditures could decline by up to 10 percent. ("Managed Competition and Its Potential to Reduce Health Spending," Congressional Budget Office, May 1993.)

Clearly, findings such as these have influenced much of the Clinton health reform proposal.

HIP AND INNER CITY, AT-RISK POPULATIONS

HIP is the largest and most experienced provider of managed care to Medicaid recipients in New York State. HIP has served Medicaid recipients since the inception of the Medicaid program in 1966. HIP was the first prepaid health plan in New York State and one of the first in the country to enroll Medicaid recipients. Voluntary Medicaid enrollment now exceeds 71,000.

Medicaid recipients and special populations, many of whom reside in the inner cities where social factors driven by poverty result in poor transportation, poor housing, inadequate schooling and low educational achievement, drug abuse, illegitimacy, and the disturbing results associated with violence, present special challenges to a health plan. However, HIP has made great strides to provide integrated health care services in these areas. HIP insists on a one class system of health care that doesn't differentiate among groups or individuals based on their ability to pay or by the source of payment we receive for their care. For example, HIP centers in federally designated medically underserved communities in New York, such as the Manhattan West center at Amsterdam Avenue and 155th Street in Harlem, the Washington Heights center on West 185th Street and Broadway, and the Bedford Williamsburg center in Brooklyn, each has a substantial mix of Medicaid as well as commercial HIP members. (See Appendix A.) This one class concept must be a major component of any health care reform proposal passed by Congress.

In addition, Medicaid recipients and other high risk populations must have the opportunity to choose from among competing health plans. Low income individuals should have the opportunity, like other consumers, to change their health plans if they aren't happy with the care they receive. HIP's experience with Medicaid recipients demonstrates that this approach can be very successful.

Despite our efforts, the health care system alone cannot nor should it be expected to solve all of the many interrelated social factors that contribute to the tremendous problems in poor, rural and urban, areas of America.

Dr. Harold Freeman, Director of the Department of Surgery at Harlem Hospital in New York who testified before this subcommittee in June, has been particularly eloquent in his appraisal of the socio-economic problems of poor Americans -- both urban and rural without regard to race or ethnicity -- and about the impact these factors have on the public health. His study of the incidence of cancer among poor Americans clearly demonstrates the very real health care consequences that occur as a result of poverty in disadvantaged groups. ("Cancer in the Socioeconomically Disadvantaged," American Cancer Society, 1990.)

Notwithstanding these challenges, HIP has been effective in providing medical care to low-income populations that suffer from poor health status often as a result of the social and environmental problems we've already discussed. Our emphasis on prevention and intervention along with vigorous efforts to educate our members have had significant results.

We have found that coordinating government programs, developing a realistic approach to costs, community rating, emphasizing a choice of plan, providing education and orientation, recognizing and responding to the special needs of Medicaid and other at-risk populations, and developing appropriate expectations for data must be essential components of any health care reform plan that is to have significant success changing health outcomes at the local -- community -- level.

Specifically, HIP assists its special needs members with unique programs. These include the Child/Teen Health Plan the goal of which is to safeguard and ensure that all Medicaid eligible children from birth through age 21 are under a continuing program of preventive and primary health care consistent with early and periodic screening, diagnostic and treatment (EPSDT) criteria; substance abuse treatment programs; family planning and reproductive health services; a good health incentive program that encourages families that are newly enrolled in HIP to obtain a base line physical; pre-natal monitoring and incentive program; and a case management program with a component targeting pregnant teenagers.

Since 1989, HIP has participated in a state demonstration project for the employed uninsured which was designed to test the ability to insure employer groups that don't offer health benefits. Current enrollment in the program is 2,340.

Since 1991, HIP has operated the Child Health Plus program, another state demonstration project that enrolls uninsured children up to the age of thirteen for outpatient services.

Earlier this year, HIP responded to President Clinton's call for a joint public-private partnership to develop innovative approaches to vaccinating children. HIP implemented a program in the spring which offered free immunizations to 10,000 preschool children, including non-members who didn't have health coverage for immunizations.

Many of these additional programs and health benefits including those in the EPSDT program have been made possible through enhanced Medicaid reimbursement in New York State. Such special care programs are extremely important if at-risk populations are to be successfully integrated into a health care delivery system that works.

THE CLINTON PLAN

HIP salutes the core principles on which the President has built his proposal for health system reform including security, simplicity, savings, choice, quality and responsibility. The President's commitment to health care reform and the impressive work Hillary Rodham Clinton has done to develop a comprehensive proposal are indeed historic. The Health Security Act's 1,342 pages should serve as a foundation on which to develop a bill that can be signed by the President by the end of this Congress. We are dedicated to helping all of

you achieve that goal. In doing so we would hope that our experience as a prepaid, group practice HMO serving diverse populations for nearly fifty years might shed some light on certain aspects of the reform process.

Specifically, the Administration should be recognized for including in the Health Security Act provisions which are responsive to the pressing health needs of inner city populations. Some of these include:

- A comprehensive benefit package which includes cradle-to-grave periodicity schedules for immunizations, tests and clinician visits.
- Provisions which would strengthen the capacity of state and local public health agencies to monitor and protect the community's health against communicable diseases and exposure to toxic environmental pollutants, occupational hazards, harmful products and poor quality health care; to educate health care consumers and providers about their role in preventing and controlling disease and appropriate use of medical services (Section 3311);
- Grants to states for core public health functions including monitoring the overall public health quality and safety of communities including assessing exposure to high lead levels which is a high priority program for many of our inner city residents; investigation and control of adverse health conditions including improvements in emergency treatment preparedness; cooperative activities to reduce violence levels in communities and activities to control the outbreak of disease; and public information and education programs to reduce risks to health such as the use of tobacco, alcohol and other drugs (Sec. 3312); and,
- Grants to community health centers and migrant health centers and grants and contracts to public and nonprofit entities to increase the capacity of individuals to utilize the services included in the benefits package. These grants would increase the number of practice sites by linking providers in underserved areas with each other and with regional health care institutions and academic health centers. In addition, grants would support services such as transportation, community and patient outreach, patient education, and translation services (Sects. 3401-3461).

We think these and other similar provisions of the Act are essential based on HIP's twenty-plus years of experience providing health services to Medicaid beneficiaries. We would ask that a copy of a white paper entitled, "Provision of Comprehensive Health Care Services to Medicaid Recipients" which includes our findings and recommendations about essential health and support services for low-income people, be included in the record. (See Appendix B.) These findings support the several sections of the Act which authorize the services mentioned above. As we all know, the Act authorizes discretionary grant and contract programs which require appropriations. Based on our experience, these core public health and support services are essential to the health of inner city low-income populations and can only be assured through adequate and sustained funding.

TAX ISSUES

There are also some significant tax issues which have been identified and which must be addressed if we are to continue to meet the demand for health care from all the populations we serve.

The Clinton plan contains several provisions which concern HIP because of the impact they would have on our status as a tax exempt organization under Sec. 501(c)(3) of the Internal Revenue Code.

First, the Act requires all health plans to offer a point-of-service (POS) product in addition to our HMO activity — the only product we now offer. POS allows the member to decide on a case by case basis whether to use the HMO's services or receive services outside the system at an additional cost to the member.

The concern of tax exempt HMOs is that the Internal Revenue Service has allowed exempt organizations to do some amount of business not directly related to their tax-exempt purposes, in this case, our HMO activity. The code does require that income tax be paid on "unrelated business" income. The Internal Revenue Service has taken the position, however, that if that "unrelated business" activity becomes a "substantial" activity of the exempt organization, the organization's overall tax exemption is threatened, in the extreme case, with revocation of that status retroactive to the date of inception. Various revenue rulings and IRS General Counsel memoranda seem to indicate that the IRS views "substantial" as approximately ten percent of the organization's business. Accordingly, any provision in the Act which merely provides that exempt organizations will pay tax on their POS income but does not address the question of "substantiality" only solves one-half of the problem.

Another concern is that many states -- Florida, Indiana, New Jersey and Ohio for example -- prohibit HMOs from offering a POS product unless the HMO obtains a license to operate as an insurance carrier -- an expensive and time consuming effort. This often involves the formation and capitalization of a new corporation, adding to the financial and administrative burdens which the Act is seeking to control.

The Act does not override these restrictive state laws, nor does it amend the Tax Code with respect to the 501(m) concern noted above. We recommend that the Act be amended (i) to permit HMOs to offer a POS product on an optional basis; (ii) to clarify that any HMO which chooses to offer POS will not thereby risk its tax exemption; and (iii) to allow for POS products to be offered under the HMO's state license as an HMO.

Another tax related concern which is not addressed in the Health Security Act relates to access to capital for tax exempt organizations such as HIP. Mr. Rangel has been a strong supporter of repealing the \$150 million cap on tax-exempt debt which is imposed on organizations exempt from paying taxes under 501(c)(3) of the Internal Revenue Code. This cap is a significant barrier to our ability to expand and renovate our health facilities and equipment. As a not-for-profit corporation, HIP looks to the debt markets as the primary source of external funds for capital investment. The alternative for HIP of having to raise capital in the taxable debt markets is considerably more costly and difficult. Under the President's plan, universal coverage would be fully implemented by 1998. Such enormous expansion means HIP, as just one plan, would have to significantly increase its capacity or face the prospect that we would have to restrict enrollment to avoid overcrowded facilities and demands for care we simply couldn't meet. We would strongly recommend that a repeal of the cap be included in any health reform legislation that passes the Congress.

ADDITIONAL CONCERN ABOUT THE ACT

There are three major features of the Health Security Act that concern HIP based on our preliminary analysis of this far reaching legislation.

First, the Act includes several substantial surcharges to health plan premiums - costs which are not now built into our price structure. These include:

- 2.5% of premium for operating costs of the alliances (Sec. 1352);
- 1.5% of premium to finance graduate medical education and academic medical centers (Sec. 1353);
- 2% of premium for contingency reserve to underwrite insolvencies of other health plans (Sec. 1204);
- 0.5% of premium for assessments during the transition period to administer a national risk pool for coverage costs for uninsured individuals (Sec. 11007);
- Subsidies in instances where there is non-payment of premium until the individual either selects a source of coverage or payment (Sec. 1323);
- Reimbursement of essential community providers (school based health programs, certified essential practitioners and Federally Qualified Health Centers) for 100% of their costs based on Medicare payment principles without regard to our having already established facilities, health care providers and equipment to provide the

- mandated benefits and services (Sec. 1431);
- A transitional national risk pool, funded by premiums and assessments against all insurers, based on market share in the health insurance market to assure coverage for any uninsured person or group unable to obtain coverage in the private insurance market. Additional premiums against health plans may be levied if premiums are not sufficient to pay claims incurred by the pool. The assessment will be 0.5 percent of premium (Sec. 11007); and,
- Alliance data requirements that will include 100% encounter reporting and electronic submission of claims data causing many health plans to incur substantial costs of revising their data systems which are not now based on individual encounters. Those costs will have to be passed on to purchasers through higher premiums.

Many of these surcharges are to support essential linkages in our health care system and they should be funded but in other ways. However, we do take strong exception to the insolvency fund as an inappropriate and expensive mechanism to protect the consumer in the event of health plan insolvency.

The fundamental problem resulting from these surcharges is their relationship to the premium cap contained in Title VI of the Act.

If health plan premium increases are to be held to the CPI then all these surcharges cannot be added to a health plan's cost structure. Based on the most current HMO industry data from the Group Health Association of America, the median profit margin for all HMOs is a 3.4% retention. HIP-New York's contribution to surplus is under 3.4% and we use that surplus to finance improvements in facilities, moderating rate increases and acquiring the latest technology. Therefore, it does not seem realistic to cap premium increases while mandating additional assessments to premium.

The Health Security Act does not permit a direct pass through of all these surcharges to health plan premiums and would result in both unnecessary rate increases and reductions in service expansion and modernization. The Act appears to be penalizing currently efficient HMOs whose administrative costs are under 8% and whose surplus funds are used only to subsidize premium increases and to improve services to members through capital expansion and modernization.

Second, we support the idea, conceptualized in the alliance system, of an integrated regulatory apparatus. However, our experience operating in three states causes us concern that the alliances as envisioned in the Act would operate as an additional layer of bureaucracy on top of the states' current regulatory structures. For example, the Act requires alliances to:

- Regulate the quality of care;
- Monitor consumer complaints;
- Review marketing literature;
- Evaluate health plan rates;
- Monitor fiscal solvency of health plans;
- Negotiate with providers to develop a budget for fee-for-service plans;
- Establish point-of-enrollment mechanisms for individuals not previously enrolled in a health plan;
- Collect and analyze utilization data from health plans;
- Operate disenrollment procedures (for cause) and re-enrollment in a different health plan; and,
- Conduct annual open enrollment periods which could require highly complex and expensive systems to track the choices of millions of people (i.e. the NYC metropolitan area) and to transfer adjusted premiums to the appropriate health plan.

All of these and many other functions will be monitored by a governing board of employers and consumers, leading inevitably to very large and expensive staffs of attorneys, actuaries, computer experts, accountants, and consultants.

Third, the alliance boundaries will be drawn by the states. As the November 5 New York Times article, "Conflict Is Seen Between Regions In Health Plan" points out, separating Long Island into one alliance and the five boroughs of New York City into another will drive up rates for inner city residents. This may occur because Sec. 1202 of the Act permits alliance areas to be based on a consolidated metropolitan statistical area instead of SMSA's. Presently, HIP community rates that entire geographic area of New York City, Long Island and Westchester, resulting in affordable premiums for all. Furthermore, the creation of separate alliances for New York, New Jersey and Connecticut will create a bureaucratic nightmare for people who live in one state, receive their health benefits from an employer in a different contiguous state and choose to get health care from a provider in the state where they work, not where they live. Additionally, health plans such as HIP could conceivably have to contribute to the operating costs of different alliances in New York City, Staten Island, Long Island, and Westchester and Rockland Counties. Another unnecessary cost would be imposed by Section 1551 which would require us to meet a minimal capital standard of \$500,000 in each alliance area, assuming that downstate NY is subdivided into several alliances as described in the Times.

While we have had only a short period of time to analyze this Act, we support its objectives and we are willing to assist with any efforts to modify it to ensure that our members in New York, New Jersey and Florida are able to continue to receive affordable, comprehensive health benefits.

HIP has noted in this testimony only a few of the structural and operational aspects which concern us and which may result in conflicting goals that will consume health dollars better used to meet the needs of our enrollees. We look forward to working with this Committee to correct some of the concerns noted above and to help shape the final legislation.

APPENDIX A

HIP Centers in Low Income Medically Underserved Communities

	Center	HMO	CHP *
11205	Bedford Williamsburg 233 Nostrand Avenue Brooklyn, NY 11205	23,289	4,424
11225	Empire Eastern Parkway Center 546 Eastern Parkway Brooklyn, NY 11225	31,155	4,101
11218	Flatbush Church Avenue Center 1000 Church Avenue Brooklyn, NY 11218	25,354	2,869
11224	Coney Island Neptune Avenue Center 1230 Neptune Avenue Brooklyn, NY 11224	10,610	2,192
10033	Washington Heights West 185th Street Center 4337 Broadway New York, NY 10033	13,555	1,923
10031	Upper Manhattan West 152nd Street Center 1865 Amsterdam Avenue New York, NY 10031	15,357	1,902
10453	Grand Concourse Center 2021 Grand Concourse Bronx, NY 10453	39,342	4,625
10451	Southern Center 326-8 East 149th Street Bronx, NY 10451	12,154	2,635

* Designates HIP's Comprehensive Health Plan for Medicaid recipients.

APPENDIX B

December, 1992

HEALTH INSURANCE PLAN OF GREATER NEW YORK

**PROVISION OF COMPREHENSIVE HEALTH CARE SERVICES
TO MEDICAID RECIPIENTS****INTRODUCTION**

The escalating cost of New York's Medicaid program, which exceed \$7 billion a year for New York City and \$10 billion statewide, have set the stage for a major restructuring of health care services delivery to Medicaid recipients. The proposed solution---shifting half of the Medicaid population from fee-for-service Medicaid to coverage by HMOs and other managed care plans---poses major programmatic and financial challenges to the public officials who must administer the program and to the providers who will deliver the care. The ambitious timetable for expansion of Medicaid managed care has left public officials and providers with limited time to plan for the expansion of existing configuration of and organize managed care services for Medicaid recipients.

An important advantage in this effort is the experience that HMOs and other private sector providers have had in serving Medicaid recipients. The largest and most experienced provider of managed care to Medicaid recipients in New York State is the Health Insurance Plan of Greater New York (HIP), which has served Medicaid recipients since the inception of the Medicaid program in 1966. HIP was the first prepaid health plan in New York State and one of the first in the country to enroll Medicaid recipients. HIP's Medicaid members voluntarily enrolled now exceeds 56,000. The current enrollment of 51,486 New York City Medicaid members in HIP represents approximately 60% of New York City's Medicaid recipients who receive managed care.

Beginning in the late 1980's, HIP increased its efforts at enrolling New York City Medicaid recipients. Within the past four years it has entered into additional contracts to enroll Medicaid recipients in Suffolk, Westchester and Nassau Counties.

HIP's experience and success in providing comprehensive managed care to voluntarily enrolled Medicaid recipients are positive indications that would ensure both quality of care and reduction in the cost of health care. The contemplated increased enrollment of Medicaid recipients in managed care will be achieved through planning with realistic goals for expansion and consideration of the special needs of the Medicaid population.

The purpose of this paper is to provide background information on

- (a) HIP's experience as a provider to voluntarily enrolled Medicaid recipients,
- (b) HIP's efforts to expand its Medicaid membership, and
- (c) the implications for the managed care initiative of HIP's extensive experience in serving Medicaid recipients. This experience if utilized will provide government the opportunity to enroll the significant numbers of Medicaid recipients envisioned for a well managed mandatory program.

1. THE MEDICAID PROGRAM

The federal Medicaid legislation that was enacted in 1965 called for the creation of a comprehensive program of health care services for low-income persons, a substantial portion of the cost of which would be borne by the federal government and the rest by the states.¹ Federal law permits, but does not require, local governments to contribute to the cost of Medicaid programs, and New York is one of the few states that requires its local governments to bear a substantial portion of Medicaid costs. The federal law sets minimum standards for program eligibility, benefits, administration, and other matters that must be met in order for a state to be eligible to receive federal funding. Within the limitations of the federal requirements, the states (in New York, local government working with the state) determine the scope of their respective Medicaid programs and are principally responsible for administering them. Every state has enacted legislation that conforms to the federal Medicaid law. Despite federal regulation of the program, the state programs differ significantly in eligibility, benefits, and other respects.

New York State enacted its Medicaid legislation shortly after the enactment of the federal legislation and has conducted a Medicaid program ever since.² The range of benefits provided to New York Medicaid recipients is extremely broad. More than 2.6 million persons are enrolled in Medicaid statewide, with 1,614,380 of them residing in New York City, 71,518 in Westchester County, 56,293 in Nassau County and 81,079 in Suffolk County.³ The Medicaid legislation requires that Medicaid recipients have the right to select the providers from which they receive medical care.

¹ Social Security Act, Title XIX, 42 USCS 1396 *et seq.*, as added July 30, 1965. P.L. 93-233.

² New York Social Services Law, Sections 363 *et seq.*

³ New York State Department of Social Services, Social Statistics, December, 1991.

The amount of federal financial support that a state receives for its Medicaid program is determined by a formula that, in theory at least, reflects the state's ability to bear the costs of the program. The federal support that New York State receives is just above the minimum federal contribution of 50%. New York, unlike most states, requires its local governments to pay a substantial share of Medicaid costs. At the present time, New York City pays 23% of the cost of its Medicaid program, New York State pays 26%, and the federal government pays 51%.

2. PROBLEMS OF THE MEDICAID PROGRAM

Despite the generous benefits provided by the New York State Medicaid program and large sums of public money devoted to it, public officials and other key commentators have repeatedly observed that there are many deficiencies in the health care services provided to Medicaid recipients and that better care could be made available at reduced cost. The severe fiscal problems of government at all levels have brought these concerns to the fore. Among the problems that have been cited frequently are the following:

(a) Lack of Access to Primary Care

Primary care should be the central component of any health care delivery system. Primary care physicians are the family doctors who see patients for routine ailments, physical examinations, and preventive care. Because their patients see them regularly, primary care physicians know their patients, identify and treat health problems at an early stage before they become more serious, and decide when a patient needs to obtain specialized care from another source.

A major problem for the Medicaid program has been a severe shortage of primary care physicians to serve Medicaid recipient who seek health care on a fee-for-service basis.⁴ New York State Medicaid reimburses physician office visits at rates ranging from \$7 to \$19.50 per

⁴ Building Primary Health Care in New York City's Low-Income Communities, Christel Brelochs, Anjean B. Carter, Barbara Caress, and Amy Goldman, Community Service Society of New York, 1990, pp. 1, 21-28; Third Annual Report to the Legislature on the Implementation of the New York State Managed Medical Care Demonstration Program, New York State Department of Social Services, February, 1991, p. 1; Managed Care Demonstration Project Implementation Plan, volume I, New York City Human Resources Administration, Family Support Administration, Office of Health Services, September, 1990, pp. i, 1-3, 7-8.

primary care visit, a rate schedule that is among the lowest in the nation and that discourages many physicians who practice in New York from accepting Medicaid patients.⁵ Without access to the normal sources of primary care, many Medicaid recipients resort to hospital emergency rooms and outpatient departments or to storefront medical offices that primarily serve Medicaid patients on an episodic basis.

(b) Fragmented Care

A problem with these substitutes for primary care is that they are often geared to missions other than that of providing continuity of primary care services: a patient sees a physician once for a specific complaint and may never see the same physician again. Arrangements for follow-up of patients are, in some cases, ineffective. Moreover, because the physician is not always familiar with the patient's medical history, he or she will lack information that would be helpful in diagnosis and treatment. Even though the technical competence with which hospital emergency rooms and outpatient clinics provide care may be very high, the lack of continuity of the patient/physician relationship and the difficulty of providing follow up care are among the reasons that the overall care provided is in many cases deficient.⁶

(c) Lack of Preventive Care

A striking result of the lack of access to care of Medicaid patients is the limited use that Medicaid patients make of preventive health care services. A recent study has shown that in some zip codes in upper Manhattan the percentages of mothers receiving inadequate prenatal care was in the range from 35% to 45%.⁷ Other services that have proven to be effective in preventing or limiting the severity of illnesses, such as screening and treatment for pediatric

⁵ Managed Care Demonstration Project Implementation Plan, volume I, New York City Human Resources Administration, Office of Health Services, September, 1990, p. 1; Primocare Inc., A Medicaid Partial Capitation Managed Care Program, New York County Medical Society and the Manhattan Central Medical Society (undated), p. 2; Primary and Preventive Care Task Force Preliminary Report, Health Systems Agency of New York City, February 23, 1991, pp. 7-8.

⁶ Managed Care Demonstration Project Implementation Program, volume I, New York City Human Resources Administration, Family Support Administration, Office of Health Services, September, 1990, p. 2; Building Primary Health Care in New York City's Low-Income Communities, Christel Brelochs, Anjean B. Carter, Barbara Caress, and Amy Goldman, Community Service Society of New York, 1990, pp. 19, 20, 25-30; Draft Report on Health Care, The Mayor's Management Advisory Task Force, April 1, 1991, pp. 13-14.

⁷ Assessment of Maternal and Child Health Services in Upper Manhattan, Health Systems Agency of New York City, February 1990, p. 66.

bronchitis and asthma, adult bronchitis, pneumonia, malignancy of female reproductive organs, diabetes, ear infections, and hypertension, are also not used as much by persons in neighborhoods with high Medicaid enrollment as they are by other population groups.⁸

(d) High Utilization and High Costs

Among the significant effects of the way that Medicaid recipients receive health care are the high levels of utilization of many types of health care services. The average Medicaid recipient receiving Aid to Families with Dependent Children ("AFDC") sees a physician 62% more often than persons of comparable age groups who are enrolled in HIP. On average, Medicaid enrollees receiving fee-for-service care have 127% more inpatient discharges than HIP members in comparable age groups. While some of the additional use of medical care is attributable to the social environment in which Medicaid patients live and to their greater vulnerability to illness than other populations, the manner in which care is provided to Medicaid patients is also a contributing factor. Lacking access to appropriate primary care, Medicaid patients often run up large numbers of visits without receiving the coordinated and continuous care that they need. They often receive inadequate treatment at the earlier stages of their illnesses, become sicker, and are more likely than the average patient to require hospitalization.⁹

The heavy reliance of many Medicaid recipients on hospitals for all types of medical care together with the high levels of utilization makes the care that they receive very costly. These factors have resulted in the paradox that although the fee-for-service care that Medicaid recipients receive is often characterized by the deficiencies described above, the amount that is spent on their care is higher than that of other sectors of the population of similar age groups, including those covered by Blue Cross, commercial carriers, and HMO's.¹⁰

⁸ Analysis of Primary and Preventive Care Needs: Central Harlem, Southwest Bronx, Bedford Stuyvesant/Crown Heights, Health Systems Agency of New York City, July 24, 1989, pp. 1-5; Building Primary Health Care in New York City's Low-Income Communities, Christel Brelochs, Anjean B. Carter, Barbara Caress, and Amy Goldman, Community Service Society of New York, 1990, pp. 17, 18.

⁹ Draft Report on Health Care, The Mayor's Management Advisory Task Force, April 1, 1991, pp. 9-13; Building Primary Health Care in New York City's Low-Income Communities, Christel Brelochs, Anjean B. Carter, Barbara Caress, and Amy Goldman, Community Service Society of New York, 1990, pp. 34, 36. Managed Care Demonstration Project Implementation Plan, volume I, New York City Human Resources Administration, Family Support Administration, Office of Health Services, September, 1990, pp. 2-3.

¹⁰ Draft Report on Health Care, The Mayor's Management Advisory Task Force, April 1, 1990, p.8.

3. HEALTH INSURANCE PLAN OF GREATER NEW YORK (HIP)

Health Insurance Plan of Greater New York is the oldest and largest prepaid health plan in the New York area and the second largest in the United States. HIP provides its 921,000 New York members (1.1 million system wide) with comprehensive health care services, emphasizes primary and preventive care, and employs advanced diagnostic and treatment techniques. Ambulatory care services are provided by six affiliated medical group practices, which provide care in HIP's fifty-four modern, attractive facilities, nearly all of which have been constructed or renovated during the past ten years. HIP's service area includes the five boroughs of New York City and Nassau, Suffolk and Westchester Counties. In addition, HIP's affiliates operate prepaid health plans in New Jersey and Florida.

HIP's corporate mission has been shaped by three historical commitments. The first is to the provision of affordable health care. HIP is a cost-conscious provider. The effectiveness of its cost containment programs has enabled it to keep its premiums at the lowest level in its service area, without compromising the quality or accessibility of the medical care that it provides. A second commitment is to maintaining the highest standards of medical care.

Rigorous criteria for selection of physicians, an effective peer review program, the most advanced medical equipment and technology, an internal quality assurance program for monitoring all aspects of patient care, and access to leading hospitals and highly qualified specialists are among the factors that contribute to HIP's ability maintain its high quality of care.

HIP's third historical commitment is to serve, to the extent feasible, all segments of the diverse population of its service area. HIP's members include persons from all social, economic, and demographic backgrounds. The diversity and inclusiveness of HIP's membership is unusual among providers of health care benefits in the New York metropolitan area, and it has contributed to HIP's success in overcoming the separation that often exists between health care services for Medicaid recipients and health care services for other population groups.

4. HIP'S ENROLLMENT OF MEDICAID RECIPIENTS

HIP has enrolled and served New York City Medicaid recipients for more than twenty years. Its role in Medicaid expanded in 1988 to include Suffolk County, where HIP has a Medicaid enrollment of about 2,595 members. HIP has also entered into contracts with Westchester County and more recently with Nassau County to provide services to their Medicaid recipients. As a result, HIP will soon be providing care to Medicaid recipients throughout its New York State service area.

The largest category of HIP's 48,884 Medicaid recipients consists of those who receive Aid to Families with Dependent Children ("AFDC"), who constitute about 69% of HIP's Medicaid members. The coverage for AFDC is comparable to HIP's comprehensive HMO coverage. Other categories of HIP Medicaid recipients receive only medical services, with hospital coverage provided to them by Medicaid.

HIP's enrollment of Medicaid recipients has increased rapidly in recent years as a result of joint efforts on the part of HIP, the New York State Department of social services, the New York City Human Resources Administration, and the Federal Health Care Financing Administration. With the cooperation of government, HIP has tried a number of different marketing methods that range from direct mail advertising campaigns to health fairs. HIP's experience has shown that the most effective method of increasing voluntary enrollment in managed health care plans is a program of one-on-one contacts, at the Income Support Centers, between marketing representatives and Medicaid recipients.

The effectiveness of this method of marketing has caused HIP to rely heavily on this approach, despite the fact that it is highly labor intensive. The number of marketing representatives devoted to the Medicaid program has been increased from three in 1987 to a current level of seventeen. The result has been a rapid increase in enrollment. During the twelve month period that ended in November, 1992, Medicaid enrollment in HIP increased by 46%, rising from 37,442 to 54,467.

Achieving this growth required that HIP overcome a number of significant obstacles. A Medicaid recipient who wishes to enroll in HIP must receive all of his or her medical care through HIP, giving up the right to use other eligible providers. For many low-income people, the possession of a Medicaid card appears to offer a range of choices about health care services that may not be available to them in many other aspects of their lives. Successful marketing of HIP's services to Medicaid recipients requires that they understand that the advantages of comprehensive coverage by HIP outweigh perceived psychological and practical advantages of a seemingly free choice of providers.

A second obstacle to growth that HIP's Medicaid enrollment effort has had to overcome is the rapid turnover in membership that occurs as a result of individuals' losing their Medicaid eligibility either temporarily or permanently. Approximately 16.83% of Medicaid enrollees cease to be eligible for Medicaid each year because they find employment, because their income levels rise above the eligibility limits, or because of delays in obtaining recertification of Medicaid eligibility. As a result of this rapid turnover, HIP's marketing staff must recruit 5,328 new enrollees each year in order merely to keep Medicaid enrollment at its current level.

Despite the difficulties of increasing Medicaid enrollment, there is every indication that the voluntary enrollment of Medicaid recipients will continue to grow. During 1992, HIP projects that Medicaid enrollment in HIP will increase by about 20%. HIP intends to maintain a vigorous effort to market its services to the Medicaid population.

In addition to its ongoing efforts to expand Medicaid enrollment, HIP is participating in special programs to serve Medicaid recipients. These include participation in a multiple HMO demonstration program for mandatory enrollment of Medicaid recipients in Brooklyn and a program to serve methadone patients that is being conducted jointly with the New York State Departments of Health and Social Services and Beth Israel Medical Center. These programs are providing HIP with further experience that will be useful in connection with participation in the managed care initiative.

5. OVERCOMING ESTABLISHED HABITS AND EXPECTATIONS OF MEDICAID RECIPIENTS

Success in providing care to Medicaid recipients requires changing the patterns of utilization that many Medicaid recipients have developed. Most commentators agree that Medicaid recipients, usually for want of another alternative, are accustomed to the fragmented and episodic style of care described earlier. They are not accustomed to a more comprehensive and methodical approach to health care delivery that includes periodic physicians. If Medicaid recipients are to take full advantage of the services available to them through HIP, they must understand how to use the system.

HIP's efforts to acquaint Medicaid members with its system of care start at the time of enrollment. All enrollment of Medicaid recipients by HIP is done in person at the Income Maintenance Centers or at HIP center. The direct contact with HIP's Medicaid marketing staff creates an opportunity for explaining the services that HIP provides and the manner in which members can use the services. At the time of enrollment, the member selects the HIP center at which he or she is to receive care, and the marketing representative assigns the new member to an HIP Medicaid Program Officer stationed at that health center. The marketing representative provides the member with the name and telephone number of the Medicaid Program Officer. In addition, the marketing representative provides the new member with written materials that explain how members can obtain access to the services HIP provides.

The role of HIP's Medicaid Program Officers is crucial to the success of HIP's ability to serve Medicaid recipients. Although HIP is committed to making Medicaid recipients part of the mainstream of its membership, it recognizes that many newly enrolled Medicaid members will have to be oriented to a comprehensive health care delivery system. HIP's Medicaid Program Officers provide each recipient with orientation, assist in selecting his or her personal physician, and inform the member of how to go about changing his or her physician and how to seek assistance in resolving problems. Medicaid Program Officers act as patient advocates, helping Medicaid recipients to obtain appointments or services when they have difficulty doing so. The role that the Medicaid Program Officers play in resolving service problems has contributed significantly to member satisfaction and to the low rate of voluntary turnover of HIP's Medicaid members.

HIP also invites each new Medicaid member to attend a group orientation session explaining HIP's system of health care delivery. Such sessions are held regularly, and members are reimbursed for the cost of transportation to and from the meeting.

HIP actively encourages its Medicaid members to make use of preventive health care services. Medicaid Program Officers explain to Medicaid recipients the advantages of routine physical examinations, screening, prenatal care, and other preventive health services. Moreover, HIP encourages all new Medicaid enrollees to obtain base-line physical examinations, and it provides them an incentive to do so by offering free health-related items such as blankets or car seats once their physical examinations have been completed. In addition to encouraging AFDC Medicaid members to avail themselves of HIP's preventive health care services, these items help members meet their health care needs and those of their children. The results of this program have been positive. A preliminary study conducted by HIP indicates that more new Medicaid members have been obtaining physical examinations than previously and that they have been having their examinations sooner than they had prior to the institution of the incentive program. A similar program encourages pregnant women to obtain prenatal care by providing free child-care items to women who keep all of their prenatal care appointments.

HIP Medicaid Program Officers track new members for a period of six months to assure that they seek and receive routine physical examinations and screening as well as any other services they need. The Medicaid Program Officers also conduct a prenatal monitoring program for all Medicaid mothers, and they track young children to assure that immunizations and routine pediatric examinations are conducted in accordance with established schedules.

Because of the positive results described above and the growth of HIP's Medicaid enrollment, HIP has increased the number of Medicaid Program Officers. The present number of eleven program officers will be increased to fourteen in July, 1991.

In addition to these special programs for Medicaid recipients, HIP has a case management program that is available to all HIP members with chronic or complicated conditions. For example, all teenage mothers are included in the case management program because they are considered to be at risk. The case management program assures that all services required by these patients are effectively coordinated, that routine prenatal visits are scheduled, and that there is appropriate follow up on all problems that arise.

HIP's Medicaid program has been successful from the standpoint of member services because it does not try to fit Medicaid into the role of a commercial account. HIP has accepted what it cannot change, such as involuntary turnover, and has found ways to deal with many potential problems through outreach, incentive programs, and special orientation programs. These endeavors have been aided by the strong support of Medicaid agencies at the federal, state, county and city levels. Such support has been essential to the effectiveness of the program.

At the same time, HIP's attention to the special needs of its Medicaid enrollees does not result in the separation of Medicaid members from other HIP members. To the contrary, all patients receive care in the same facilities and from the same doctors. Apart from enhanced programs to meet needs of this population, Medicaid members are not distinguishable from other categories of members enrolled in HIP. The success that HIP has had in enrolling and providing care to Medicaid patients represents a significant step towards the goal of including Medicaid recipients in the mainstream of medical care that serves non-Medicaid populations.

6. RESULTS OF HIP'S MEDICAID INITIATIVES

HIP's efforts have been successful in many respects. Medicaid enrollment in HIP, which had been static or declining until 1986, has now started to grow rapidly, despite the large number of members who have been forced to withdraw from HIP as a result of termination of their Medicaid eligibility. HIP's retention rate for members who do not lose their eligibility has been high. One reason for the high retention rate is that Medicaid recipients who choose HIP are largely satisfied with the services they receive. The results of surveys conducted by the New York City Human Resources Administration to determine satisfaction of Medicaid recipients have consistently shown that there is a high level of satisfaction with HIP.

HIP has been effective in providing improved care to a population that generally suffers from poor health status and social and environmental problems that make the provision of health care services more difficult than for the non-Medicaid population. Medicaid members enrolled in HIP receive baseline physical and prenatal care and obtain coordinated care through their primary care physicians.

In addition to providing Medicaid enrollees with access to quality care, HIP has significantly reduced unnecessary utilization of health care services. The AFDC Medicaid population in general has a hospital utilization rate of 157 discharges per 1,000 recipients. AFDC Medicaid recipients enrolled in HIP have an average utilization of 98 discharges per 1,000. Apart from the positive effect on quality of care, this 37.8% reduction in hospital discharges is significant from a financial point of view, since well over half of HIP's expenditures are attributable to the costs of hospital care for its members. A similar improvement in utilization patterns applies to physicians' services: 6.6 visits per year for a non-HIP AFDC Medicaid recipient compared to 3.8 visits per year for AFDC Medicaid recipients enrolled in HIP, resulting in a 42.4% reduction in visits.

At times, concerns are expressed that Medicaid recipients may not be receiving enough services. Although no one has determined the optimal level of services for a given population group, it is notable that HIP's utilization rates for its membership as a whole are in line with industry norms. The rates of utilization for HIP's Medicaid recipients, although lower than for Medicaid fee-for-service, are higher than those for non-Medicaid members of HIP. Hospital discharges for HIP Medicaid patients are 42% higher than for non-Medicaid members, and patient days are 35% higher. These differences reflect special needs of the Medicaid population

that result from social and environmental factors leading to increased risk of illness. They are also an indication of HIP's willingness and ability to adapt its level of service to meet the special needs of Medicaid recipients.

HIP's success in reducing unnecessary utilization has benefited Medicaid recipients enrolled in HIP by minimizing the number of days that they must stay in the hospital, by reducing the number of unnecessary laboratory tests they must submit to, and by sparing them the inconvenience of making numerous visits to physicians when a smaller number would suffice. Inappropriate or excessive use of medical services is a form of poor quality care that affects the provision of services to the Medicaid population¹¹, and HIP's system of health care delivery is an effective means of addressing such utilization.

7. FINANCIAL SAVINGS TO GOVERNMENT

Enrollment of Medicaid recipients in HIP has already produced substantial cost savings for the state and city governments, and those savings will increase as HIP's Medicaid enrollment increases. HIP's monthly per capita premium for providing care to Medicaid recipients is \$131.77 per person per month. The cost of fee-for-service Medicaid coverage for a comparable mix of age groups is \$175.68 per month. The 33.32% reduction in costs based upon HIP's existing New York City enrollment of 40,842 will result in annual savings for the twelve month period beginning July 1, 1992, of approximately \$22 million as compared to the cost to government of providing Medicaid services on a fee-for-service basis. Approximately \$5.5 million of this amount will represent direct savings to the New York City government. Further increases in enrollment in HIP will result in a corresponding increase in the savings.

The substantial savings to government that are being realized from the enrollment of Medicaid recipients in HIP are the result of HIP's structure, the efficiency with which it provides care, and the effective use of cost containment measures. HIP's system for delivering care eliminates financial incentives for unnecessary laboratory tests and for other forms of

unnecessary utilization. In addition, HIP provides prescriptions for Medicaid recipients not enrolled in HIP. As a result of these and other arrangements, HIP has successfully addressed many of the problems and abuses that have led to the high cost of providing Medicaid coverage.

In addition to cost containment measures, Medicaid expenditures for HIP coverage are reduced by the use of community rating to determine the premiums that Medicaid pays to HIP. In a community rating system, premiums for all enrollees are equal, regardless of age, health, and other factors that bear upon the amount of health services that a particular population group

¹¹ Managed Care Demonstration Project Implementation Plan, volume I, New York City Human Resources Administration, Family Support Administration, Office of Health Services, September, 1990, pp. 2-3; Draft Report on Health Care, The Mayor's Management Advisory Task Force, April 1, 1991, Chapter 1, p. 7.

might be expected to require. In other words, each member's premium is based upon the average cost of healthcare coverage for all members of the plan. Medicaid recipients, on the average, use more medical services than the average of HIP's non-Medicaid members. This is true even in a managed care setting because environmental and other factors make Medicaid recipients more prone to illness than the general population. The higher rate of utilization by Medicaid recipients is not reflected in the premium paid to HIP for Medicaid coverage, with the result that Medicaid costs are lower than they would be if the premium were based upon the cost of serving Medicaid patients.

8. CONCLUSIONS AND RECOMMENDATIONS

HIP has demonstrated its ability to provide services to the Medicaid population in a manner that can attract a significant enrollment on a voluntary basis. It has also shown that, despite continuous involuntary terminations of members who cease to meet Medicaid eligibility requirements, HIP can attract new Medicaid recipients at a rate that is rapid enough to increase its Medicaid enrollment substantially. HIP anticipates that this increase will continue.

HIP is also prepared to participate actively in efforts prompted by the recent legislative action¹² expanding managed care for Medicaid recipients through a mandatory program. However HIP's experience suggests that enrollment of a substantial portion of the Medicaid population with managed care providers raises issues that must be addressed. The effectiveness of any health care delivery system depends in large measure upon the active participation and cooperation of those who are receiving the care. There is a causal link between the success of HIP in providing care to Medicaid recipients and the fact that each person enrolled in HIP made a decision to do so. Whether persons assigned to HIP or limited to a selection of HMO's that includes HIP would be prepared to learn about HIP's system and to adhere to its methods of operation is not entirely clear. To the extent that Medicaid recipients are not motivated to do so, the switch from fee-for-service to managed care may be less beneficial, in terms of both improved health care and financial savings, than might be anticipated on the basis of HIP's experience to date. The enrollment of a large number of Medicaid recipients in a short period of time might exacerbate this problem, by making it difficult to provide necessary outreach and orientation services to Medicaid enrollees to make the most effective use of the health care services made available to them.

The proposal to emphasize managed care in the Medicaid program offers significant potential for improving health care services, while reducing the high costs of the Medicaid program. At the same time, it is essential that government officials and providers of managed care work together to develop solutions to the potential problems of a massive expansion of managed care in the Medicaid program. HIP and other managed care providers have had a great deal of experience with Medicaid recipients over an extended period and extensive knowledge of what works and what does not work in providing managed care to a Medicaid population.

¹²

Chapter 165, Laws of 1991.

This experience and the information derived from it should be of substantial value to government officials in carrying out the ambitious expansion program that is contemplated. The following are among the lessons to be drawn from HIP's experience:

(a) Governmental coordination Medicaid is an extremely complex program, and responsibility for its administration is divided among all three levels of government. HIP's success in providing services to Medicaid recipients is, in large measure, attributable to the ability of federal, state, and local governmental officials to work together. HIP has enjoyed a

high level of cooperation from government that has proven that problems will be resolved promptly and definitively. Continuation of this high level of coordination and cooperation is an absolute condition for the success of the program for expanding Medicaid enrollment.

(b) Realistic approach to costs and program goals The desired benefits of increased use of managed care in the Medicaid program can be attained only if governmental officials continue to view cost containment goals in the context of the overall program objective of providing high quality comprehensive health care. Governmental financial pressures and the need to control Medicaid costs have had a positive effect as an impetus for correcting many of the problems with fee-for-service Medicaid. But there is a danger that excessive emphasis on the cost saving aspect of these reforms, unrealistic expectations about the amount of such savings, and underestimation of the challenges of the proposed expansion of managed care could impair the success of the managed care initiative. The understanding that governmental officials have of these difficulties has been crucial to the success that HIP has had to date in caring for Medicaid recipients. A continuation of this view of Medicaid reform is necessary to permit HIP and other quality providers of Medicaid services to contribute to progress toward cost containment and improved services.

(c) Community Rating As discussed above, Medicaid recipients are more costly to serve than HIP's non-Medicaid population. At present, the additional cost to HIP of the Medicaid program can be accommodated in the community rate because Medicaid recipients constitute a relatively small portion of HIP's total membership and because a large portion of HIP's Medicaid population is in the AFDC category. Should there be a significant increase in HIP's Medicaid population or in the proportion of Medicaid members who are in more costly categories, such as Home Relief, alternative rates, which would soften the cost impact on HIP while still producing significant savings for government, would need to be considered by government. Such methods have already been used in New York State.

(d) The importance of choice HIP's success in serving Medicaid recipients appears to be linked to its members' decision to choose HIP as the source of their medical care. Medicaid recipients who are involuntarily assigned to a managed care provider may have less incentive to adapt to a new system of health care delivery. The provisions in the recent

legislation requiring that at least three plans be offered¹³ is a step towards assuring some degree of choice of providers, but it is not clear whether that will prove to be sufficient to motivate Medicaid recipients to use managed care systems appropriately. Implementation of mandatory managed care programs should be closely monitored and adapted to the special needs of the Medicaid recipients assigned to managed care providers.

(e) Emphasis on education and orientation One of the clearest lessons from HIP's experience is the importance of close connection between the marketing of HMO services to Medicaid recipients and the education of Medicaid recipients to use HIP's system appropriately. Any program of mandatory assignment of Medicaid recipients to managed care providers should place even greater emphasis on member education and orientation.

(f) Recognize special needs of Medicaid recipients and provide appropriate services to meet them Medicaid recipients have greater health needs than the general population of comparable age groups. HIP has found the administrative case management functions of the Medicaid Program Officers to be invaluable in helping to assure that Medicaid recipients receive the services they need.

(g) Limit administrative demands for data To the extent that the emphasis on managed care is aimed at providers who serve mainly non-Medicaid patients, it would be helpful for governmental authorities to reconsider some of the more burdensome data requirements that are imposed on Medicaid providers. HIP has extensive internal monitoring procedures, and it is regulated by numerous government agencies at the federal, state, and city levels. While additional data might be appropriate in a situation involving a new HMO or managed-care program or in one whose membership is predominantly Medicaid, such a high level of scrutiny should not appear to be necessary for established programs, the bulk of whose membership is Medicaid recipients.

HIP's experience as a provider of comprehensive services to Medicaid recipients has been a positive one for HIP, its physicians, and the members it serves. This experience indicates that well-managed HMO's are in a position to play a significant role in the effort to improve the quality, accessibility, and cost effectiveness of medical care to Medicaid recipients through the use of managed care. HIP remains committed to an enhanced role in serving Medicaid recipients who become HIP members, whether on a voluntary or a mandatory basis.

¹³

New York Social Services Law, Section 364-j(6)(b).

Chairman RANGEL. Mr. McEntee.

STATEMENT OF GERALD MCENTEE, INTERNATIONAL PRESIDENT, AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, AFL-CIO; ACCCOMPANIED BY STANLEY HILL, INTERNATIONAL VICE PRESIDENT, AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, AFL-CIO; AND EXECUTIVE DIRECTOR, DISTRICT COUNCIL 37, NEW YORK

Mr. MCENTEE. Thank you, Mr. Chairman. I am Gerald McEntee, president of the American Federation of State, County and Municipal Employees. We are the Nation's largest union of public employees and health care workers. On my right is Stanley Hill, our executive director of District Council 37 representing 130,000 New York City Government employees of which 30,000 work in the city's public hospitals and Public Health Department.

We appreciate the opportunity to testify about the impact of President Clinton's health plan on inner-city residents and health care providers. Among AFSCME's 1.3 million members are more than 100,000 acute care hospital workers, most of whom work in inner-city public hospitals, including Harlem Hospital and New York City's other public hospitals.

They wash the floors, they change the beds, serve the meals, provide nursing services and treat patients and when their shifts are over, most return home to the same inner-city neighborhoods where they work. Public hospital workers see the failing of America's health care system every day, children dying of preventable diseases because their parents couldn't afford immunizations.

We see emergency rooms filled with people in crisis who couldn't find a doctor, but public hospital workers also know that their hospitals are the only place where no one will be turned away, the only health security for many inner-city residents. The national health reform plan to be enacted by this Congress must protect and assist these hospitals in the transition into a new delivery system so they can continue to be there for all who need them. It is time for Congress to do its part and pass comprehensive health care reform.

We must guarantee true health security for all Americans. Like you, Mr. Chairman, we have been critical of managed competition and the President's plan would in certain respects promote it. However, unlike the bill sponsored by Congressman Jim Cooper, the President prevents the kind of managed competition that would deny coverage to millions of Americans.

The President requires an employer mandate, guarantees a comprehensive benefit package which includes preventive care and provides assistance to low-income families and businesses. For years, AFSCME has had favored a single-payer plan because it is the most simple and efficient way to provide health security for all Americans whether they live in Harlem or Scarsdale, South Central L.A. or Beverly Hills.

We continue to support single-payer reform principles and will work with you, Mr. Chairman and the administration, to ensure that the principles of universal guaranteed coverage and choice are incorporated into the plan. We do commend the President for his

bold leadership. He has proposed a health security plan that guarantees insurance to everyone and uses the power of the Federal Government to organize the financing and structure of a new health insurance system. While we strongly support basic elements of the President's plan, we are very concerned that disproportionate share funds will be nearly eliminated. The Clinton plan provides health benefits to almost all uninsured people, but public hospitals will continue to be one of the few sources of health care for an estimated 3.2 million undocumented residents, 400,000 of whom live in New York City and public hospitals will also be forced to absorb the cost of care to low-income people who cannot afford the copayment requirements in the Clinton plan.

We are also concerned that the President has decided to cap subsidies for low-income individuals. If subsidies are not available to all who need them then we will once again see our emergency rooms fill up with people who couldn't get care when they needed it and our public hospitals will pay the bill.

As you know, Mr. Chairman, the original intent of disproportionate share funds was to cover the broad range of additional services needed by low-income patients in urban communities, costs that will inevitably continue after national health reform. The President's proposal to designate certain providers as essential community providers and give them additional assistance is a good one, but any definition of essential community providers must include hospitals as well as clinics and essential community providers will need the funds to keep and attract the doctors they need.

For inner-city hospitals to survive they must be given a fair chance to compete. After decades of neglect, their infrastructure is crumbling. A 1993 study by the National Association of Public Hospitals estimates that public hospitals have at least \$15 billion in unmet capital needs and yet they cannot get the capital they need.

Without capital, many public hospitals will not survive the transition to national health care. We will lose what is one of our greatest resources in inner-city neighborhoods.

Finally, our last point and absolutely critical, that the enormous changes proposed in the President's plan not harm health care workers. Public and private hospitals will undergo major transformations as the plan for managed competition becomes effective. Already in anticipation of the President's plan hospitals and HMOs have escalated the pace of mergers and consolidations.

Threats of privatization are increasing. Layoffs have occurred in many facilities both public and private. Some of these changes may be necessary and may be even unavoidable, but one thing is clear. It is essential that the bill adopted by Congress recognize the experience and commitment of health care workers. Their skills must be utilized in the new delivery system. Health care worker protections must be included in the plan. They are essential to its success and essential to AFSCME support of the plan.

Mr. Chairman, the time for national health security has finally come and we are privileged to be able to work with you and the administration to make comprehensive health care reform a reality for all Americans.

Thank you.

[The prepared statement follows:]

**TESTIMONY OF GERALD W. McENTEE
AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES,
AFL-CIO**

Mr. Chairman and members of the Committee, I am Gerald W. McEntee, President of the American Federation of State, County and Municipal Employees (AFSCME), the nation's largest union of public employees and health care workers. I am accompanied by Stanley Hill, Executive Director of AFSCME District Council 37, representing 130,000 New York City government employees of which 30,000 work in the City's public hospitals and public health department. We appreciate the opportunity to testify about the impact of President Clinton's health plan on inner city residents and health care providers.

Among AFSCME's 1.3 million members are more than 100,000 acute care hospital workers, most of whom work in inner city public hospitals, including Harlem Hospital and New York City's other public hospitals. They wash the floors, change the beds, serve the meals, provide nursing services, and treat patients, and when their shifts are over, many of them return home to the same inner city neighborhoods where they work.

Public hospital workers see the failings of America's health care system every day – children dying of preventable diseases because their parents couldn't afford immunizations and emergency rooms filled with people in crisis who couldn't find a doctor. But public hospital workers also know that their hospitals are the only place where no one will be turned away – the only health security for many inner city residents. The national health reform plan to be enacted by this Congress must protect and assist these hospitals in the transition into a new delivery system so they can continue to be there for all who need them.

It's time for Congress to do its part and pass comprehensive health care reform. We must guarantee true health security for all Americans. Like you, Mr. Chairman, we've been critical of managed competition, and the President's plan would, in certain respects, promote it. However, unlike the bill sponsored by Congressman Jim Cooper, the President prevents the kind of managed competition that would deny coverage to millions of Americans. The President requires an employer mandate, guarantees a comprehensive benefit package which includes preventive care, and provides assistance to low-income families and businesses.

For years, AFSCME has favored a single payer plan because it is the most simple and efficient way to provide health security for all Americans, whether they live in Harlem or Scarsdale, South Central Los Angeles or Beverly Hills. We continue to support single payer reform principles and will work with you and the Administration to ensure that the principles of universal, guaranteed coverage and choice are incorporated into the plan.

We commend the President for his bold leadership. He has proposed a health security plan that guarantees insurance to everyone and uses the power of the Federal Government to organize the financing and structure of a new health insurance system.

While we strongly support much of the President's plan, we are very concerned that disproportionate share funds will be nearly eliminated. The Clinton plan provides health benefits to almost all uninsured people, but public hospitals will continue to be one of the few sources of health care for an estimated 3.2 million undocumented residents, 400,000 of whom live in New York City. And public hospitals will also be forced to absorb the cost of care to low-income people who cannot afford the co-payment requirements in the Clinton plan.

We are also concerned that the President has decided to cap subsidies for low-income individuals. If subsidies are not available to all who need them, then we'll once again see our emergency rooms fill up with people who couldn't get care when they needed it, and our public hospitals will pay the bill.

As you know, Mr. Chairman, the original intent of disproportionate share funds was to cover the broad range of additional services needed by low-income patients and urban communities – costs that will inevitably continue after national health reform.

The President's proposal to designate certain providers as "essential community providers" and give them additional assistance is a good one. But any definition of essential community providers must include hospitals as well as clinics. And essential community providers will need the funds to keep and attract the doctors they need.

For inner city hospitals to survive, they must be given a fair chance to compete. After decades of neglect, their infrastructure is crumbling. A 1993 study by the National Association of Public Hospitals estimates that public hospitals have at least \$15 billion in unmet capital needs, and yet they cannot get the capital they need. Without capital, many public hospitals will not survive the transition to national health care. We will lose what is one of our greatest resources in inner city neighborhoods.

Finally, it is absolutely critical that the enormous changes proposed in the President's plan not harm health care workers. Public and private hospitals will undergo major transformations as the plan for managed competition becomes effective. Already, in anticipation of the President's plan, hospitals and HMOs have escalated the pace of mergers and consolidations. Threats of privatization are increasing. Layoffs have occurred in many facilities, public and private.

Some of these changes will be necessary and unavoidable. But one thing is clear: it is essential that the bill adopted by Congress recognize the experience and commitment of health care workers. Their skills must be utilized in the new delivery system. Health care worker protections must be included in the plan. They are essential to its success and essential to AFSCME's support of the plan.

Mr. Chairman, the time for national health security has finally come. We are privileged to be able to work with you and the Administration to make comprehensive health care reform a reality for all Americans.

Thank you.

Chairman RANGEL. Mr. Hill, do you have anything to add?

Mr. HILL. Very little to add except to say last night Mr. Chairman by actually chance, I went to a town meeting where Congressman Maloney called it and Congressman Gephardt was there, but many of our workers were there at the NYU Center. They talked about what President McEntee talked about. They talked about what Marc talked about and what Ken talked about in terms of dealing with health care in New York City.

As you know—and you have been a tremendous ally and friend and a person whenever we called on you to get help in the public hospitals you have been there. I want to emphasize, we want to make sure that the public hospitals are competitive with this plan, that we don't lose out as Dr. Billy Jones, the president of the corporation—we talked about this.

We don't want to see the baby out of the bathtub. We want to make sure that not only worker protection but good patient care is delivered continuously so that the people can be proud to come into a public hospital like I was proud last night when Pam Briar, the director of Bellevue Hospital said that the JCAH came in and gave Bellevue Hospital an A-1 rating. I felt good about that. She complimented the workers, but I said, "It was your leadership that was important."

When you go to Goldwater Hospital and see a sparkling hospital which, if you go there and see how the workers are performing and taking care of patients because there is great leadership. I can go on and say many other directors in the hospitals are trying to keep the public hospitals alive.

President McEntee is right about the infrastructure; we need help in that area. People like Jim Bowler, a colleague of mine who has given many, many years of his life to saving the public hospitals—this is something that we believe in and we want to make sure in terms of this universal health care plan that the public hospitals play a role, that the worker protections are there.

The workers said last night "We don't want to see layoffs as a result of this plan. We want to see working together to help the patients."

When I was 18 years old, my basketball career was extended because I got good care at Bellevue Hospital. I didn't know what HIP or Blue Cross was, but my mother and father had that, and I was lucky.

When I was 51 years old, 7 years ago, I got seriously ill. I was taken to NYU and given the best care there, too. So whether it is public or private, the key is good, quality care and I am very thankful that we have that in many hospitals in New York City today and a lot of it comes through the commitment and care that you see at this table.

I wanted to add that bit of information.

Chairman RANGEL. Thank you.

Mr. McAndrews.

STATEMENT OF LAWRENCE A. MCANDREWS, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS

Mr. MCANDREWS. Thank you, Mr. Chairman.

I am Lawrence McAndrews, the president and chief executive officer of the National Association of Children's Hospitals and Related Institutions. I come not as an expert on tax law, but I have served for the last 20 years in a not-for-profit hospital setting most recently as chief executive officer of Children's Mercy Hospital in Kansas City.

I will be brief and try to focus on the questions that you asked today. Children desperately need comprehensive health care reform. One-third of children depend on Medicaid or charity for their health care services and that proportion continues to grow because children are at the front lines of the relentless erosion in private health insurance.

Children's hospitals strongly support the invaluable leadership of the President working with Congress to move the Nation to comprehensive health reform. Children need comprehensive reform.

In reevaluating the standards for tax exemption for not-for-profit hospitals, the Children's Hospitals support the focus of the President in making sure that the definition of community benefit is grounded in a recurring assessment of the community's needs and the means to meet it.

A children's hospital's most important strength is the constancy of community support for its fulfillment of a mission of clinical care, education, research and advocacy all centered around health and well-being of the child.

Children's hospitals are a safety net of essential providers to the most vulnerable children of inner-city and other distressed neighborhoods.

Children's hospitals devote an overwhelming disproportionate share of their care to children of low-income families and children with chronic or congenital conditions. Although we hope it will be substantially diminished, charity care will continue to be a necessity for a variety of reasons even under a health proposal as comprehensive as the President's. This will be especially true for the children in families of inner-city and other areas that are medically underserved.

Community benefits beyond charity care will continue to require society's support through the financial advantage tax exemptions affords to not-for-profit health care providers such as children's hospitals.

In the world of children's hospitals, their mission of medical education, research, and advocacy are also invaluable components of their community benefit, essential to providing access not just acknowledging health care coverage. Because health care will not eliminate charity care and will not replace the need for education, research, front-line service delivery and advocacy for children, we believe we as a society should remain committed to the principle of community benefit as the foundation for tax exemption.

If health care reform such as the President's proposal challenges us to reexamine the standards we expect tax-exempted hospitals to

meet, then the children's hospitals believe that these standards should move in the direction of the President's own legislation.

A hospital's community benefit should be defined by the community in which it serves. Recommendations such as the President's calling for hospitals to undertake regular assessment of community need with participation of representatives of the community and explicit planning to meet those needs is the best way to sustain the essential bond between a tax-exempt hospital and its community.

Children's hospitals believe that it is consistent with their own historic commitment to mission to returning year after year, decade after decade to missions of serving the children of their community.

While my remarks have focused on the measurable and tangible, the percent of low-income children children's hospitals serve, children with chronic and congenital conditions and charity care, perhaps the most important point to understand, but which is not tangible, is the philosophical orientation, which are not-for-profit hospitals.

As a hospital CEO, I knew the organization had to have a profit for long-term survival, but we constantly struggled to see how many services could be delivered while still making a profit. For example, providing a sexual abuse service in our emergency room would never make money, but was a needed service.

In a for-profit setting, I would have dismissed having the service because it would have been a poor return on investment. While making a profit is a good discipline, it is not the primary motivation of the not-for-profit children's hospitals.

Not-for-profit hospitals have always been a hybrid organization in this country, a marriage between business and social purposes. Today we need to make sure that marriage has accountability to the public as we continue to provide those services.

I appreciate the opportunity to testify. I would be happy to try to answer any questions you might have.

Chairman RANGEL. Thank you.

[The prepared statement follows:]

The National Association of Children's Hospitals
and Related Institutions, Inc.

Testimony

The Impact of Certain Tax-Related Aspects
of the Administration's Health Care Reform Proposal
on Residents of Inner-City and Other Distressed Neighborhoods

Lawrence A. McAndrews
President and CEO
National Association of Children's Hospitals
and Related Institutions

Subcommittee on Select Revenue Measures
Committee on Ways and Means
U.S. House of Representatives
Washington, DC

November 9, 1993

Mr. Chairman, I am Lawrence A. McAndrews, President and CEO of the National Association of Children's Hospitals and Related Institutions. On behalf of NACHRI, I want to thank you for the opportunity to testify before the subcommittee today.

I come before you not as an expert in tax law or as one who can claim he understands all of the details of the President's legislation. Instead I come as one who has devoted his entire career to community service through the delivery of health care by not-for-profit hospitals, most recently as the President and CEO of the Children's Mercy Hospital in Kansas City, MO, before assuming the leadership of NACHRI.

I appear on behalf of a community of children's hospitals and pediatric departments of major university teaching hospitals, virtually all of which are deeply devoted to service to the children of families of the inner city, especially low income neighborhoods of the inner city. In my testimony before you this morning, I would like to emphasize six basic points:

- 1) Children's hospitals are a safety net of essential providers to the most vulnerable children of inner city and other distressed neighborhoods. Children's hospitals devote an overwhelmingly disproportionate share of their care to children of low income families and children with chronic or congenital conditions.
- 2) Children desperately need comprehensive health care reform. One third of all children now depend on Medicaid or charity for their health care services, and that proportion continues to grow, because children are at the frontlines of the relentless erosion in private health insurance. Children's hospitals strongly support the invaluable leadership of the President, working with Congress, to move the nation to comprehensive health care reform. Children need comprehensive reform.
- 3) Although we hope it will be substantially diminished, charity care will continue to be a necessity for a variety of reasons -- even under a health care reform proposal as ambitious and comprehensive as the President's. This will be especially true for the children and families of inner city and other areas that are medically underserved.

4) Community benefits -- beyond charity care -- will continue to require society's support through the financial advantages tax exemption affords not-for-profit health care providers such as children's hospitals. In the world of children's hospitals, their missions of medical education, research, and advocacy are also invaluable components of their community benefit -- essential to providing access, not just acknowledging health care coverage.

5) In re-evaluating the standards for tax exemption for not-for-profit hospitals, the children's hospitals support the focus of the President in making sure that the definition of community benefit is grounded in a recurring assessment of the community's need and the means to meet it. The children's hospital's most important strength is the constancy of community support for its fulfillment of a mission of clinical care, education, research, and advocacy all centered around the health and well-being of the child.

6) In all of their advocacy for health care reform, children's hospitals emphasize the message that health care reform -- standard benefits, the competitive market place, financing, and the replacement of the Medicaid safety net -- must be tailored to fit children's needs. When it comes to children, one size won't fit all.

Children's Hospitals Are Safety Net Providers

Because of their missions of serving all of the children of their communities, virtually all children's hospitals have become major providers of care to children of low income and disadvantaged neighborhoods -- especially in the inner cities. Many children's hospitals are located in the heart of the inner city -- such as Children's National Medical Center in Washington, DC, or Children's Hospital of Michigan in Detroit, or Children's Hospital Oakland in Oakland, California. But even children's hospitals not located in the city center remain essential providers of care to the children of inner city communities. For example:

- Children's hospitals on average devote more than 44 percent of their care to children assisted by Medicaid, and nearly 50 percent of their care to children whose families depend on either Medicaid or charity.
- It is not unusual for a children's hospital to devote 50 percent, 60 percent, or more of its care to children of low income families.
- Medicaid pays children's hospitals substantially less than the cost of care. As a consequence, almost all children's hospitals are recognized by their states to be eligible for Medicaid disproportionate share payment adjustments.

Because of their missions of making care available to all of the children of their communities, children's hospitals have continued, year after year, to devote more of their care to children assisted by Medicaid -- at the same time that both the percentage of all private practice pediatricians caring for children under Medicaid has declined, and the average percentage of a pediatrician's practice devoted to Medicaid recipients also has declined. In many inner cities, the children's hospital, like the community health center or the public hospital, has become both primary and specialty care provider to families with low incomes.

Children's hospitals also are a critical safety net for children with chronic or congenital conditions -- cancer, HIV infection, heart malformations, kidney disorders, cystic fibrosis, cerebral palsy, and other conditions. Although they represent only one percent of the nation's hospitals, free-standing children's hospitals care for 25 percent of all hospitalized children with these challenging conditions. Children's hospitals and the

pediatric departments of university medical centers represent only seven percent of the nation's hospitals, but in many instances they care for the vast majority of children with chronic or congenital conditions. As a consequence:

- Children's hospitals on average devote more than 70 percent of their care to children with at least one chronic or congenital condition.
- Children's hospitals on average devote more than 66 percent of their care to preschool children, who often require the most intensive nursing and medical care.
- Children's hospitals on average devote nearly one third of their beds to infants and children in intensive care units, compared to only 10 percent of beds in community hospitals.

Children Need Health Care Reform

Children -- and especially the children of inner city and low income neighborhoods served by children's hospitals -- desperately need comprehensive health care reform. They are at the frontlines of the erosion in commercial health care coverage, because the continued loss of dependent coverage remains the principle cause for that erosion. Even with the enormous expansions in Medicaid coverage for children of low income families in recent years, approximately 9.5 million children continue to be uninsured.

Children cared for in children's hospitals also are especially vulnerable to the other forms of erosion in health care coverage -- pre-existing condition exclusions, life-time maximums, and portability restrictions -- because they often have the most demanding health care needs. For example, children's hospitals on average devote over two-fifths of their care to "catastrophic cases" -- children whose inpatient care results in charges greater than \$50,000. That represents proportionally 2.5 times the catastrophic cases a pediatric program of a community hospital sees.

Children's hospitals believe that if you care about the needs of all children, as they do, you have to support the achievement of comprehensive health care reform. That is why the leadership of the President -- and Congressional leaders -- mean so much.

The Continued Need for Charity Care

There is no question that comprehensive health care reform, such as the President has proposed, will go a long way toward reducing the need for charity care and reducing the existence of a two-tiered health care financing system. NACHRI is strongly encouraged by the President's recognition in his health care reform proposal for the continued need to secure the role of the safety net provider through protections for "essential providers" serving medically underserved populations, the establishment of a "vulnerable populations adjustment" for hospitals, and protections for academic health centers in their care for the most challenging medical cases.

At the same time, even under the President's proposal, charity care will continue to exist for a variety of reasons:

- Not all residents will be covered under the President's plan. As many have recognized, the President's plan does not afford to immigrants lacking legal documentation coverage of the guaranteed benefit package to which legal residents and U.S. citizens would be entitled. In those regions of the country that have received the greatest numbers of undocumented immigrants, charity care will remain a necessity.
- Not all health care services will be covered under the guaranteed benefit package. The President proposes a broad guaranteed benefit package -- as good or better than many managed care plan's benefits today. Nonetheless, it will not

cover all of the legitimate needs of children with special care needs. For example, as now written, the limits the President's plan imposes on outpatient occupational, physical, and speech therapies in the guaranteed benefit plan would exclude coverage for such essential services for the child with chronic and congenital conditions. For Medicaid eligible children, the President's plan offers the promise of medically necessary care, but it will be limited by a capped entitlement for subsidies for low income people and small businesses.

- Even covered benefits will not always be paid for. The President's plan will strongly reinforce the already existing trend toward the enrollment of more and more Americans, through both commercial coverage and Medicaid, into managed care plans in which emphasis is placed on utilization review. Children's hospitals often experience rejection of payment for covered benefits, because utilization reviewers -- often untrained in the medical requirements of the kinds of children with special care needs typically seen by children's hospitals -- reject the recommended care pediatric specialists and their colleagues recommend.

The President's plan makes a strong commitment to trying to achieve access, not just coverage. But we know from the experience of Medicaid how difficult it can be to achieve access, even with the best of coverage. For example, despite the fact the Medicaid EPSDT program is widely recognized to offer among the most comprehensive benefits children could enjoy under either commercial or public health insurance, millions of Medicaid children still have not experienced the Medicaid guarantee of medically necessary care.

It is our great hope that charity care will dramatically diminish, but it is the overwhelming experience of children's hospitals in caring for children with private coverage today, Medicaid coverage today, and managed care coverage today that comprehensive health care reform will not eliminate charity care, and in the most challenging communities of our country it will take years to reduce significantly.

Community Benefits Beyond Charity Care

Because of their missions of service to their community, children's hospitals believe strongly that the community benefits upon which their tax exemption is founded both do exceed -- and should exceed -- charity care alone, both today and under the hoped for future of comprehensive reform. Certainly many children's hospitals make very substantial contributions to the financing of children's health care -- not through charity care alone -- but through the seriously inadequate base reimbursement rates Medicaid provides. Their missions, buttressed by their tax-exempt status, are the most important reasons why children's hospitals around the country have continued to care for more and more children under Medicaid, even in the face of its inadequate reimbursement.

But the community benefits of children's hospitals go far beyond both charity care and uncompensated Medicaid care. It is the missions of the children's hospitals -- supported by their tax exempt status -- which have enabled children's hospitals to play such an important and constructive role in the training of pediatricians and other pediatric health care professionals. Consider the following:

- Children's hospitals alone train more than a quarter of all pediatricians. Children's hospitals and pediatric departments of university teaching hospitals train the majority of pediatricians and the vast majority of pediatric subspecialists.
- Despite the fact that medical education overall has produced a disproportionate number of medical specialists, pediatric medical education has achieved the exact opposite -- it has

vastly exceeded the very goals hoped for medical education overall. Today, 85 percent of pediatricians are devoted to primary care practice. And the vast majority of graduate pediatric medical residents enter primary care practice. For medical education overall, it's only 15 percent.

- Because of their locations and missions of service to the children of inner cities and disadvantaged neighborhoods, children's hospitals are training the pediatricians who serve the inner city. For example, The Children's Hospital in Boston -- among the nation's most prestigious pediatric academic health centers -- trains nearly half of all the pediatricians who serve the children of Boston's inner city.

Medical education is only one of the significant community benefits children's hospitals provide beyond charity care. Certainly children's hospitals throughout the country are recognized as critical centers of excellence in the research and treatment of pediatric heart disease, cancer, sickle cell anemia, HIV infection, and many other conditions.

Children's hospitals also provide benefits to their community by being on the cutting edge of health care delivery. And in many inner cities, that has meant that it has been children's hospitals that were the first to respond to HIV infection among children and women -- to provide needed care when it was nowhere else available and to develop the models of care that have become the standard of care. Only a tiny fraction of the nation's hospitals, children's hospitals nonetheless care for the majority of hospitalized children with HIV infection, and in doing so have become essential providers of the continuum of primary, acute, and long term care these children and their families require. Similarly, children's hospitals have broken ground, because of their missions of being ready to care for all of the children of their communities, in serving the infants born to substance abusing parents and the children of physically or emotionally abused families.

Children's hospitals have also been at the center of the movement of recognizing and establishing the need for emergency medical services designed specifically to meet the needs of children -- something the Institute of Medicine just this past summer said requires substantially more public recognition and investment. But out of this commitment to emergency medical services for children and their service to inner city and disadvantaged neighborhoods, children's hospitals also have been at the frontlines in coping with the consequences of the mounting gun violence across the country that is injuring or killing more and more children. Children's hospitals in city after city are experiencing dramatic increases in the numbers of gun shot wounds to children, which they receive.

This experience has compelled the children's hospitals to fulfill another important benefit to their communities -- to become advocates for children both inside and outside the walls of the hospital. For example, their first hand experience with children as the victims of violence has persuaded more and more children's hospitals to speak out against violence, to speak out for gun control, to educate their communities about what is happening to their children and what needs to be done to protect children from firearms. And through their national organization -- NACHRI -- the children's hospitals have adopted a strategy to reduce children's access to firearms and minimize children's death and disability resulting from firearm use.

These community benefits -- the training of the very best in primary as well as subspecialty health professionals, the conduct of pathbreaking research, the delivery of services to children at the cutting edge of societal change, and the advocacy for the community's responsibility to meet its children's most basic needs -- are all sustained and will need to be sustained by society's financial and moral commitment to them through tax exemption.

New Standards of Tax Exemption

Because health care reform will not eliminate charity care and will not replace the need for education, research, frontline service delivery, and advocacy for children, the children's hospitals believe we, as a society, should remain committed to the principle of community benefit as the foundation for tax exemption.

If health care reform, such as the President's proposal, challenges us to re-examine the standards we expect tax exempt hospitals to meet, then the children's hospitals believe that these standards should move in the direction in which the President's own legislation and various states point. A hospital's community benefit should be defined by the community in which it serves. Recommendations such as the President's, calling for hospitals to undertake regular assessments of community need, with participation of representatives of the community, and explicit planning to meet those needs, is the best way to sustain the essential bond between a tax-exempt hospital and its community. Children's hospitals believe that is consistent with their own historic commitment to mission -- to returning, year after year, decade after decade, to their missions of serving the children of their communities.

Because children's hospitals believe in the importance of meeting the needs of the community, they also believe that it is important to allow flexibility in defining community. For example, a children's hospital unquestionably serves its immediate neighborhood and city and should be accountable to them. But depending on its services, a children's hospital also may serve a larger state, multi-state, or national community, precisely because its services are so specialized. Assessment of community need and planning to fulfill that community need should take into account larger regional and national communities served. For example, the State of New York's law on community service plans specifically recognizes that tax-exempt hospitals may serve multiple populations and multiple communities, for which the hospital should plan.

Health Care Reform Tailored to Fit Children's Needs

It is not the purpose of this hearing to discuss all of the complexities of health care reform in general, or the President's proposal in particular. But let me emphasize what the children's hospitals try to say each time we speak out for health care reform. It must be comprehensive, but it also must be tailored to fit children's needs -- in terms of guaranteed benefits, management of the competitive marketplace, cost containment, and the replacement of Medicaid, the nation's largest and most important public safety net for health care for children. The children's hospitals are especially appreciative to the chairman for his recognition of children's special needs in health care reform through his support of House Concurrent Resolution 126, introduced by Representative Bob Clement (D-TN), calling on Congress to address the special needs of children in health care reform.

Conclusion

While my remarks have focused on the measurable and tangible -- percent of low income children, children with chronic and congenital conditions, and charity care -- perhaps the most important point to understand, but is intangible, is the philosophical orientation of hospitals which are NOT-FOR-PROFIT.

As a hospital CEO, I knew the organization had to have a profit for long term survival but we constantly struggled to see how many services could be delivered while still making a profit. For example, providing a sexual abuse service in our emergency room would never make money but was a needed service. In a for-profit setting, I would have dismissed having the service because it would have a poor return on investment.

Tax exemption is not just a legal term, it is an orientation and philosophy which through the years has contributed enormously to the public good.

I appreciate the opportunity to testify. I would be happy to try to answer any questions you might have regarding our views on tax exemption particularly or our views on health care reform in general.

The National Association of Children's Hospitals
and Related Institutions, Inc.

January 7, 1994

Ms. Jane Fitzgerald
Subcommittee on Select Revenue
Committee on Ways and Means
1105 Longworth House Office Building
U.S. House of Representatives
Washington, D.C. 20515

Dear Jane:

As a follow-up to our discussion last month, I wanted to provide you with additional information about children's hospitals' involvement in substance abuse prevention and treatment of drug-exposed children and adolescents.

Everyday children's hospitals see the long term affects of substance abuse in the delivery of care to high-risk children. A 1990 survey of NACHRI member hospitals found that children's hospitals are seeing an increasing number of infants and children who are drug-exposed usually requiring treatment shortly after birth; drug-exposed infants have multiple, very complex medical and social problems; these infants require multidisciplinary care often in the neonatal intensive care unit; and treatment is very costly and is either covered by Medicaid or is uncompensated.

Children's hospitals provide services to high-risk children ranging from community education and counseling programs for children and families, to neonatal care for drug-exposed infants, to therapeutic day care for children suffering the long term affects of substance abuse. For example;

- **Children's Hospital Oakland, Oakland, CA** Children's Hospital sponsors The Center for the Vulnerable Child, a federally and privately funded hospital based center that provides comprehensive health care services -- including home visits, counseling, case management, and therapeutic day care -- to drug-exposed infants and foster care children. The center teaches parenting and developmental skills to substance abusing mothers, provides them with health care services, and operates an aggressive outreach program to refer high-risk children and pregnant women for services. Children's Hospital is also a co-sponsor of the Hall of Health, a interactive museum that educates about 18,000 children a year in grades 5 through 12 about addictive drugs, alcoholism, peer pressure and other issues confronting school aged children. Children's Hospital has recently received a state grant to quantify the impact of the Hall of Health on children visiting the museum.

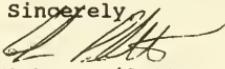
Children's Mercy Hospital, Kansas City, MO The Children's Mercy Hospital chairs the Kansas City Metropolitan Drug Abuse Council which was established to investigate the size and scope of substance abuse in the greater Kansas City Metropolitan Area. As a result of the council's findings, several community-based initiatives were developed, including a Children's Mercy program, funded by a federal Abandoned Infants Assistance Grant, that provides intensive home care services to families and their infants perinatally exposed to drugs. Children's Mercy also sponsors a therapeutic day care for drug-exposed children and successfully advocated with the state legislature to facilitate the enrollment of pregnant women in substance abuse treatment programs.

Children's hospitals also sponsor substance abuse prevention programs that target children and families in the community as well as inpatient and outpatient populations. For example, Valley Children's Hospital in Fresno, CA, conducts a one day seminar for children and adolescents on substance abuse; The Children's Hospital in Boston, MA, includes substance abuse prevention programs in their school-based clinics; and the Phoenix Children's Hospital in Phoenix, AZ, sponsors "Project Prevention" -- a live theater conducted in schools with a drug and alcohol prevention message.

Children's hospitals sponsor many different types of prevention and treatment programs for high-risk children, including drug-exposed children. If you have any questions or would like additional information, please let me know.

And again, thank you for the opportunity for NACHRI to testify at the Subcommittee's November 9 hearing on the impact of the Administration's health care reform proposal on inner-city residents and provisions for tax-exempt hospitals.

Sincerely,



John C Pilotte
Associate for Government Relations
and Health Care Policy

Chairman RANGEL. I certainly agree with you that community benefit should be the foundation for tax exemption. Frankly, I did not understand the questions being raised by the previous person who testified who said that if indeed they are no longer providing that service, don't take away the tax exemption. Give them new responsibility.

You are saying that even if the charity cases go down there is always more than enough to provide an extra service to a community to deserve the tax exemption; is that your testimony?

Mr. MCANDREWS. Yes, sir.

Chairman RANGEL. I agree with you 100 percent. Delivery of service is not just reimbursement and certainly with the progressive and exciting programs that children's hospitals have had around the country, I am certain there will be more than enough that is not covered by the President's proposal.

Mr. Hill, as relates to municipal hospitals as an example with the dramatic increase in patients that would have coverage under the President's program, how do you see that you would be cut out of the competition? You do the job that you have to do under very severe budget restrictions and it would seem to me that this program should be just a shot in the arm to pump more money into that system and there has to be an assumption that cities cannot walk away from their own institutions merely because they too are not-for-profit.

I guess—how can you guarantee that these things—how can you best protect yourself to make certain that you are the recipient of this added coverage and not the victim of competing against other institutions?

Mr. MCENTEE. We would hope that it would work that way. We would hope that it would be a shot in the arm and that the cities would not walk away. I guess we are kind of afraid that maybe we will be shut out in terms of where the doctors want to work, that we will shut out maybe in terms of these networks of hospitals that will be possibly coming into existence under at least some of the President's ideas, that people would be—now that they have access, now that they have this card rather than go to a city hospital or the emergency room, that they would pick out somebody like Columbia Presbyterian or a hospital like that—as long as the playing field is even, we believe as Stanley has said and you know in many cases we think the city hospital network in New York provides some of the finest services provided anywhere in the country and in the city of New York.

As long as the playing field is even, as long as we are not shut out of the networks, as long as we have the doctors that will participate in our hospitals, and the fact that for years in many of our hospitals they have shown capital neglect—I think the administration to a degree at least recognizes in their legislation to provide some money in terms of the capital infrastructure for public and city hospitals in New York, but we don't see near enough money to bring them up to speed in terms of the competition with some of the other hospitals, and we hope that with your leadership that you can help in that particular area.

Chairman RANGEL. I would need help in that area because if the hospital insurance card allows patients to shop as to where they

want to receive the service, then municipal or not it would mean that you have to effectively compete—it doesn't necessarily mean you have to provide the same type of services that you are providing now.

It doesn't really necessarily mean that people would want to leave Harlem if they thought that you were now in a position to do more than you were doing before. It would seem to me that as you work with public officials surrounding municipal hospitals, since you know they would want you to have better than an equal playing field that you might see how you can improve your ability to compete knowing that you have, as children's hospitals will with children, you have a high degree of dedication, of outreach, of sensitivity of employees coming from the same community so that is a plus that you can't get out of town in terms of health care.

It is a plus that people have an understanding of the culture, the problems of the people that come there, even when it comes to speaking the language. I think though that we have to work together to make certain that we have a plan to out bargain some of the people that may not even want your clients.

Mr. MCENTEE. We agree 100 percent.

Chairman RANGEL. I would like to work with you on that.

Mr. MCENTEE. No question about it. We have great concern. You and Stanley and others followed the recent mayoral race in New York City. I remember Mayor-elect Giuliani talking about privatizing four of the city hospitals. So our people are fearful of that and that some of the things that are possibly coming down the road, and we want to work with you and other responsible members of the community—once again we are talking about so often the minority communities within the inner-city.

These have been jobs that have been provided to people that literally have allowed them to escape that circle of poverty that they have never been able to get out of before. I get a little aggravated and irritated.

We spend all these subsidies in terms of farmers. We can't even find them on the census any more. People get upset about closing of a veterans' hospital and what is going to happen to the workers and we are concerned about that, what is going to happen to the vendors in the communities and we are concerned about that, then we hear concern about a military base and what is going to happen to those jobs.

Here we are in inner cities where people have climbed out of poverty and gotten these jobs and we detect a lack of concern in that area. We want to be involved in worker protections and where they go in terms of this legislation and the inner-city hospital network and where it goes in terms of this legislation.

Chairman RANGEL. It seems to me this is an item that should be on the New City Council's agenda and that rather than waiting to see whether you can compete you should allow some of us to help you to see what might be the new direction in which municipal hospitals can go.

Just as in nonprofits that have to find—everything is not going to be covered and sensitivity and understanding is something that you can't get on a piece of plastic. So we may want to see how we can really make the municipal hospitals truly community hospitals,

which they are, and have served every immigrant or new group that has come into the city and hiring them at the same time.

I wouldn't wait for the Federal Government to give you a new role. I think there are exciting challenges that the increase in revenues plus a cooperative spirit from local government could do.

Mr. Wolfert, as relates to coverage by HIP now, if my family was covered by HIP and my teenage son became addicted to cocaine, he would be covered under my policy?

Mr. WOLFERT. Yes, he would.

Chairman RANGEL. After counseling, what would happen? Do you have any idea as to what coverage he would be eligible for or how long or under existing—

Mr. WOLFERT. The standard package, the 30 inpatient and 60 outpatient days is as it exists, and we have a drug-free program.

Chairman RANGEL. Who runs that?

Mr. WOLFERT. HIP does. We have a licensed article 31, 587 to 588 mental health systems within the HIP system.

Chairman RANGEL. Do you get many of your insured with this particular problem—in other words, would one of your insured want to go someplace else or take advantage of the treatment that you are offering?

Mr. WOLFERT. They normally take advantage of the treatment available by our plan.

Chairman RANGEL. And what—it is drug free. You would be anxious to keep down the cost of the service to the patients just as relates to efficiency, wouldn't you?

Mr. WOLFERT. Yes, we would like to hold the line. What we do, depending upon the nature of the presentation, we make any kind of arrangement that is necessary to meet the problem that a patient has.

Chairman RANGEL. I am sorry.

Mr. WOLFERT. If we find that our internal program does not have the appropriate resources or the appropriate kind of modality to address a particular presentation, then we make arrangements with the provider that does have that expertise and capability.

Chairman RANGEL. You would then have a list of providers that your people could look at depending on how the case is diagnosed?

Mr. WOLFERT. Yes, we do.

Chairman RANGEL. Suppose your insured said that "I am not interested in being cured, but I sure would like to reduce my habit," how would you handle that? "I don't want long-term curing, but my habit is costing me too much money."

Mr. WOLFERT. We would attempt to counsel that individual that that is not the appropriate way to address what is ailing them and would try through either group or individual sessions to try to make the person understand that what they need to do is deal with the addiction itself, not a reduction in their dependency to whatever it was they were addicted to.

Chairman RANGEL. Mr. Salmon, I assume that you would get a lot more than HIP would because HIP would mean that somebody is working or someone is insured, but you do get some patients that really are not looking for long-term cure right?

Mr. SALMON. That is true.

Chairman RANGEL. You can counsel all you want, but you are only going to be able to get as much cooperation as the patient is able to give?

Mr. SALMON. What we try to do with the patient that does not want to get involved in long-term, intensive treatment is to basically keep the door open to safety net treatments. For instance, we have ready access to detoxification. We do have methadone maintenance for people who are opiate dependent and that is a long-term treatment.

We also have shorter-term residential treatment for people who are more interested in intensive treatment and we have hospital treatment for people where there is a medical and psychiatric involvement as well as an addiction problem.

The most important piece is to try to keep the person engaged in the system. If they don't seem ready for intensive treatment, I think the point is to try to let them know that you know that and not give them a treatment that is going to be a waste of basic resources, but to tell them that the treatment will be there when they are ready to come in and to keep them engaged in your system.

It is one of the benefits of managed care systems that they can in fact keep the patient, the knowledge base of what that patients needs. They have that. For instance, we know if somebody has had repeated detoxifications, we can work with a provider—if that patient goes into a program that they don't normally go to, we can let the provider know that the patient has a long history of treatment and maybe this is the time that they are ready to get serious and to do more treatment.

I think there are real pluses to a managed approach particularly for mental health and substance abuse treatment.

Chairman RANGEL. Do health managers ever get together and just discuss in terms of what the reimbursement rates are as to what would be the least expensive way to treat a particular patient? I know that doesn't sound as professional as it should, but you have to think of how much money you are getting, how much money you are paying, and a lot of counseling can be very expensive and methadone, if you don't have 30 days or 90 days, normally can take care of people for a long time.

I don't know how this is going to work if I come in with my card to HIP or if I come in with my card to you who is going to look at me and determine what modality I get involved in and I don't know how well you want me or how badly you would just like to get rid of me, which is a subjective evaluation as to whether or not I ever would be cured, which would be one of the diagnosis.

I don't know whether or not we are going to improve the accountability of drug treatment, because as I know it, there is no real legal requirement to run a drug rehab, is there, in New York?

Mr. WOLFERT. At least in relationship to HIP—

Chairman RANGEL. No. I meant if I open up a clinic and if I had some political strings, get a doctor or two, a counselor or two and a couple of beds—I don't have to go to school to run a clinic, do I?

Mr. WOLFERT. I would assume that there would be licensing that would be required, but I don't know.

Chairman RANGEL. With all the ex-addicts running clinics, I assume there is no training needed. Would you not say that most clinics are run by ex-addicts?

Mr. SALMON. I think that recovering people constitute a major portion of the treatment population.

Chairman RANGEL. I am not talking about staffing; I know that. I am just talking about CEOs. What about it—when I was in Albany—

Mr. SALMON. I think for therapeutic communities, that has been true historically. I think it is less true now. As drug and alcohol treatment come together, and as mental health influences start to take over. I think you see more professionalization of the top level clinicians and managers.

I think in the early days of the drug treatment communities it was certainly true that the CEO and president very often was a person in recovery as well.

Chairman RANGEL. I am not too concerned about the treatment I will get at HIP, but I have a high concern who I might be farmed out to and what standards are being used by HIP now to determine who you are giving a contract to.

Mr. WOLFERT. We review each referral program against our philosophy and approach to handling a person. The head of HIP's mental health system does this personally. If a program does not meet with our standards as well as our philosophical base on which we approach dealing with mental health and substance abuse programs they would not be a program that someone would be referred to.

Chairman RANGEL. Do you know of any programs in New York City that are on your preferred list that your mental health counselor would look at?

Mr. WOLFERT. Brooklyn Psychiatric is one off the top of my head.

Chairman RANGEL. We have a lot of methadone mills if you will that are operated by a lot of hospitals that have more than their share of doctors and psychiatrists and they keep the beds filled and they get reimbursed. You don't ask them a lot of questions about their success rates because that is insulting.

I just want to know now that—we should have an expansion now that everyone has a card and they don't have to negotiate a bed. I would think that we are going to get more providers for addict rehabilitation, is that not so?

Mr. RASKE. You would think so.

Mr. SALMON. I don't think so. I think actually we will make better use of existing resources.

Chairman RANGEL. Isn't there a shortage now of beds and slots?

Mr. SALMON. It depends on a number of things. If you insist on fixed-length-of-stay models of treatment, it is fairly easy to argue there are shortages. In Massachusetts, we have pretty much changed to individualized treatment and find that in fact there seem to be enough beds.

Outpatient is a much more expandable service. At least in Massachusetts I don't think there is a major shortage of upfront acute beds. There is a shortage of longer-term beds for patients who need longer-term care, the halfway house recovery, therapeutic kind of care. That is in part because of longer care, you get somebody into

a program and if they are successful, they are there for 3 to 12 months, there is not much turnover and a filled bed is filled for 1 year.

Chairman RANGEL. Secretary Brown is listening to this testimony. He is in the room and I welcome your presence, Secretary Brown. It is hoped that in the very near future he will have the authority to make the same types of shifts in his domestic budget as he has been authorized to do in his international budget, and so the areas that he should be looking toward seeing how there could be first the proper allocations in the first instance and then second to make those adjustments based on the needs of those people that are seeking treatment.

I have not really heard the case that has been made for methadone by those people who only provide that as an option and it would seem to me that if I was selling a program that involved methadone, and if my profits were based on the number of patients that were attracted to it, that I just don't see how you would see me referring this patient to drug-free programs. I would not know what that judgment was based on.

My 89-year-old mother was in a local city hospital, and the doctor that treated her on 6 different occasions and said that she had to go to surgery in order for this thing to happen. I wondered why because at her age all I wanted was a second opinion. I notice that every time I called him, he was in surgery. I reached a conclusion that he did surgery best rather than thinking about other modalities that he was just not that familiar with.

I don't know how it is going to work now since we don't have that many standards—there is very little if any accountability in the Federal Government, but I gather we have got to rush into this and try to find some standard and we will need your expertise to assist us in doing it.

I think and staff agrees that we may have to call this panel together—not you Jerry and Stanley—we have to do those things back home because the needs of public hospitals are different depending on the community in which they are located and I work very closely with Larry Gage—do you know him?

Mr. HILL. No.

Chairman RANGEL. He was with Califano and he is the director of the Public Hospital Group that is involved in the American Hospital Association, but we will get together in New York, because we had to pull the public hospitals out because they have different types of problems.

I want to thank you, Ken. My question to you is that as you see the losses of the city of New York under the present draft proposal, certainly don't other cities that suffer with the same type of formulas have the same problems?

Mr. RASKE. Yes, Congressman. There are a number of other cities that will have a similar kind of problem. The ingredients for the problem are basically having high Medicare penetration, a lot of Medicare elderly patients, having a lot of teaching programs and having a pretty good Medicaid program which means the amount of uninsured in the area is not as great as it would be in other places.

You kind of mix those ingredients together and you can have the outcome being negative or fairly substantially negative.

Chairman RANGEL. It would seem to me that we could best deal with that problem if you would find your colleagues who have a similar interest. They all don't have to come under the same line, but if you see they are targeted to be 70, 80 percent, tell them to reach out to the Members and the Congress. If you can organize your providers, I can organize the Members. I might have a cup of coffee with some staff.

I think that we could do better and we will concentrate on the members that are on the committees of jurisdiction and we can handle it.

This has been a very interesting panel and I probably will be getting in touch with all of you in different ways to help us as we try to figure out how to dress up this frame that has been given to us by the President.

I tried to convince the President that as they have raised the consciousness of the Nation as to the importance to do something about a health care system that is very expensive and increasing in cost, and they presented us with a package, but more than that a challenge so that now most people say "for God's sake, do something no matter what you are doing," that it would seem to me that if they could consider the cost of poverty and homelessness and joblessness and drugs and crime in the same way, not necessarily to come up with an answer, but to talk about the hundreds of billions of dollars that we are losing especially in competition and productivity.

Just the length of time and the cost of keeping someone in jail is not a thing for an industrialized country to accept. To me in a large way it will reduce as well the cost of health care since so many diseases are directly related to poverty.

I hope that if you can come up with people that have spent some time in studying that relationship, as Dr. Freeman has at Columbia, we can bring them together and instead of talking about doing the right thing because it is humane we can talk about doing the right thing because it saves money.

Thank you very much.

We understand that attorney Edelman had to leave so what I and the staff have agreed to do is to compile the many questions that were raised here and then we would present them to your office and then you can ask the Secretary to respond.

Thank you.

The hearing is adjourned.

[Whereupon, at 3:45 p.m., the subcommittee was adjourned, to reconvene subject to the call of the Chair.]

[Submissions for the record follow:]

American Hospital Association



Capitol Place, Building #3
50 F Street, N.W.
Suite 1100
Washington, D.C. 20001
Telephone 202 638-1100
FAX NO 202 626-2345

**Statement
of the
American Hospital Association
before the
Subcommittee on Select Revenue Measures
Committee on Ways and Means
U.S. House of Representatives
on
Hospital Tax-Exempt Status and Health Care Reform**

November 9, 1993

Introduction

This country is at an historic juncture in the development of social policy. A consensus is emerging around the goal of universal health coverage for all Americans. AHA and its members have a longstanding commitment to meeting the health care needs of this country, and welcome the focus on the health status of the American people and the health care delivery system. As the reform debate has focused on the twin goals of access and cost containment, AHA and its members have advanced a vision of reform to accomplish those goals. It calls for universal access, restructuring of the delivery system, and adequate financing. The members of the AHA are ready to assume their share of responsibility for making the necessary changes to meet those goals. At the same time, it is important that other policies be examined against the health policy goals and be aligned to support their achievement. Health care reform can not succeed in isolation.

Implications for Hospital Tax Exemption

With the promise of universal health insurance coverage, some are questioning the continued need for hospital tax exemption. President Clinton's health reform proposal rightly preserves community benefit as the standard for awarding tax-exempt status to hospitals. The Administration's commitment to guarantee health insurance coverage to all, and the American people's support for access to health care, place health status and the delivery of health care among the top priorities of this country. Continuation of tax exemption for hospitals and other charitable health organizations under the community benefit standard is a means for this society to reinforce its commitment to universal access and health status. The award of tax exemption recognizes the charitable hospital's dedication of its resources to improving the health status of its community. It helps support the hospital's ability to place the needs of its community at the forefront of its decision making.

As reform progresses it will become clear what the new health care environment requires. The charitable concept must evolve to reflect the times. The basic expectations of charitable hospitals will remain the same: to dedicate their resources to meeting the health care needs of their community. But what specifically they must do to fulfill those

expectations will be identified community by community. Throughout the transition, however, whether as participants in or organizers of the new delivery system, the work of tax-exempt hospitals and the partnerships they forge can be expected to meet a commitment to the larger goal of improved health status.

Universal coverage does not undercut the legal basis for tax exemption. The underpinning for charitable tax exemption is public support for activities that serve the larger good — a concept that encompasses the broadest range of public purposes. The governing body of a charitable organization has a fiduciary duty to see that the organization is organized and operated to fulfill its charitable mission; its resources must be dedicated to that purpose. Any benefit that flows to private parties must be incidental to carrying out its public purpose. When it undertakes business commitments, those decisions must be consistent with accomplishment of its mission. When it pays for goods and services, the commitment of resources should reflect the value of their contribution toward fulfillment of its purpose.

Since 1969, the promotion of health has explicitly been recognized as a purpose meriting tax exemption. Health care organizations may be awarded tax-exempt status by demonstrating that they promote health in a manner that benefits the community as a whole. The premise underlying the community benefit standard is that the promotion of health in a manner that benefits the larger community serves a public purpose. The promotion of health alone is not sufficient, however; how it is done, when, and for whom are important factors. All health care providers have a professional responsibility to provide high quality services. Tax exemption requires more. The focus is not on what the hospital does, but whether those actions respond to community need. Providing charity care has been only one way to demonstrate benefit.

Universal coverage does not eliminate the purpose for exemption. Providing access to coverage does not address all of the needs related to health status. Access to insurance coverage alone will not assure access to health services. Access to health services does not necessarily mean improved health. Focusing only on medical intervention does not address the needs related to health. Universal coverage creates the capability to pay for service, but of itself does not guarantee that services will be available when and where needed, or that all who need services will be reached. Access does not assure that service is received at the most effective point.

Meeting the community benefit standard means making the needs of the community the focal point. Benefit to the community becomes the screen against which decisions are made and the measure of success. The hospital must know the community to identify its needs, and work with the community to appropriately respond. Is information available to encourage a healthy life style and personal responsibility for health? Is there outreach and early intervention to prevent and minimize the effects of illness? Is there support for individuals and families to prevent institutionalization, and allow independent living?

Responding only to medical needs falls short of addressing the larger issues of health status. The tax-exempt provider has the responsibility to exert leadership and take the initiative on matters of importance to health. Are efforts coordinated to address the interdependence of the needs for food, shelter, and family planning, with health status; to address violence in the neighborhoods, in the schools, and in the home? Not all that is needed can or should be done by the hospital alone.

The community benefit test is still a sound and viable basis for awarding tax-exempt status to hospitals. It places the focus at the local level and examines the merits of individual situations against the community environment in which they serve. The issue has been and should continue to be whether they are providing public benefit. Has the

hospital conducted itself -- made decisions, used its resources, leveraged its influence -- in a way that benefits the entire community. Exemption is given in return for the commitment to meet the community's needs.

The President's Proposed New Requirement for Charitable Health Organizations

The Administration's proposal also includes a new statutory requirement that a charitable health care organization, with the participation of community representatives, assess the health care needs of its community and develop a plan to meet those needs. This change is consistent with AHA's vision of a reformed health care system. AHA has proposed restructuring health care delivery by establishing networks of hospitals, physicians and others that would provide a seamless continuum of care at the community level. As envisioned by AHA, these health networks would be responsible for maintaining and improving the health status of their enrollees and addressing the health status of the larger community, through partnership with others in the community. The delivery system would consist of patient centered, community based networks, focused on health status and accountable to the community.

Conclusion

Continuing tax-exempt status for community benefit hospitals will make an important contribution toward achieving the goals of universal access and improved health status.

**Written Testimony of
The Catholic Health Association of the United States
on Tax Exempt Hospitals
To The Subcommittee on Select Revenue Measures
Committee on Ways and Means
November 9, 1993**

The Catholic Health Association of the United States is pleased to present views on the role of tax exempt hospitals and healthcare reform.

The Catholic Health Association is a national organization of over 1200 Catholic hospitals and long-term care facilities, their sponsoring organizations and systems. Throughout our seventy-eight year history, CHA has taken a leadership role in advocating high standards of healthcare for all persons. Care and services to the poor - whether it be in inner cities, the primary focus of this hearing, in rural areas, or elsewhere - has been of particular concern to this association and our membership.

Since 1986, the Catholic Health Association has been a consistent advocate for universal converge in a redesigned healthcare system. Our healthcare reform proposal, Setting Relationships Right: A Proposal for Systematic Healthcare Reform, includes many of the features of the President's "Health Security Act."

CHA's proposal is anchored in six fundamental values which are rooted in the Judaic-Christian tradition:

- Healthcare is a service, not a mere commodity to be exchanged for profit.
- Public policy must serve the common good.
- Every person is the subject of human dignity.
- The needs of the poor should receive special priority.
- The must be effective stewardship of resources.
- Tasks should be performed at appropriate levels of organizations.

Applied to the discussion of the Subcommittee today, these values lead to the following principles:

- Public policy should encourage the service orientation of the healthcare system.
- Focusing on the common good, not-for-profit healthcare providers should respond to broad community needs, not solely the needs of an enrolled population.
- Every person has the right to access high quality healthcare services.
- There will continue to be a need for mission-driven healthcare providers who view the provision of services to the poor as a moral priority.
- Local community members are in the best position to evaluate whether their healthcare organizations fulfill a charitable purpose.

The Catholic Health Association has also taken a leadership role in advocating tax-exempt not-for-profit healthcare facilities be accountable to their communities. In 1989, CHA published The Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint. It has been widely used within and beyond Catholic healthcare. We also developed, with the American Association of Homes for the Aging, a version of the document for nonprofit long term care facilities.

Last year, after consultation with Catholic and other not-for-profit healthcare leaders, CHA developed and distributed "Standards for Community Benefit," calling for development of community benefit plans that describe how the facility will address community needs and problems, particularly those of the poor, frail elderly, minorities and other underserved and disadvantaged persons. The standards are attached to this testimony.

CATHOLIC HEALTH ASSOCIATION POSITION ON CONTINUING TAX EXEMPTION OF NOT-FOR-PROFIT HOSPITALS

The Catholic Health Association believes that the promise of health care reform for near-universal access to healthcare services and elimination of most uncompensated care does not alter the appropriateness or necessity of granting federal tax exemption to not-for-profit healthcare organizations that provide community benefit. We urge this subcommittee to recommend retention of tax exemption for qualified not-for-profit hospitals.

Our testimony will describe three primary reasons for continued tax exemption of community benefit healthcare organizations.

- **Healthcare is traditionally and ideally a service, not a commodity that responds well to competition and commercial forces. Tax exemption helps preserve the service orientation of healthcare organizations.**
- **Not-for-profit hospitals will continue to have a role in serving the poor and disadvantaged.** Even in a most generously designed healthcare system, some individuals and communities (especially rural and inner-city locations) will not be well served. They will remain dependent on not-for-profit providers establishing services in their areas.
- **The community benefit role of not-for-profit hospitals goes beyond free care to the poor.** Programs and services for the broader community will continue to be characteristic of these institutions as they work independently and collaboratively to address community-wide health problems and needs.

Healthcare as a Service

The history of hospitals is one of religious and community leaders responding to needs of communities by creating services and shelter to the poor, sick, dying, and elderly. The first hospitals were mission-driven in the truest sense of the term. There was little or no compensation for services and members of communities supported these early institutions with financial and volunteer assistance.

As the healthcare system changed in the types of persons served, services provided, and the availability of government and private financing, healthcare remained and is today, fundamentally a service. It is performed best, we believe, by mission-driven organizations carrying out their mission in contemporary terms.

CHA has joined members of this committee and others in being concerned that commercial values and the competitive environment in which healthcare facilities have operated in recent years have had a negative effect on the essential service and community orientation of many not-for-profit healthcare providers.

We believe that healthcare reform could aggravate this competitive environment and further encourage commercial behavior by not-for-profit healthcare facilities. Healthcare reform, as currently being discussed, shifts financial risk from purchasers of healthcare (government and employers) to providers. Healthcare plans and providers would be forced to compete on the basis of cost as well as quality and services. While it is hoped that these developments will result in the desired lower cost and higher quality, they also present threats to the service and community orientation of providers.

Intense price competition in some communities could unleash commercial influences that overwhelm the professional and service ethos in American healthcare. Unless healthcare reform and related policies retain and improve incentives for a strong service orientation, the result could be excessive commercialization and an inadequate focus on the needs of persons and communities.

Tax exemption, with its requirements for community benefit and prohibitions against private inurement and private benefit, is one safeguard against commercial values overtaking the professional and service orientation of individual not-for-profit facilities and the healthcare system as a whole.

We support provisions in the Health Security Act that call for tax exempt providers to assess the healthcare needs of their communities and develop plans to meet those needs. Whether additional standards concerning private inurement, private benefit and community benefit will be needed is yet to be seen. We can see merit in putting into the tax code requirements that general service hospitals have emergency rooms and that tax exempt hospitals not discriminate against Medicare and

Medicaid patients. Nevertheless, we recommend the advisability of such requirements be thoroughly considered.

In the meantime, as the system evolves, we urge the Internal Revenue Service continue scrutiny of tax exempt healthcare provider business practices and continue to provide guidance in the form of General Counsel Memoranda and other issuances that give direction to healthcare providers and others in the formation of not-for-profit healthcare networks and plans.

Hospitals' Charitable Purpose Continues: Care of the Poor

The "charitable purpose" basis for tax exemption has historically had a dual interpretation: relief of poverty and community benefit. The Catholic Health Association believes that not-for-profit tax exempt healthcare organizations should and will continue to demonstrate that they serve a charitable purpose under both interpretations.

CHA believes that there will be a continuing role and responsibility for not-for-profit, tax exempt healthcare organizations to serve the poor and disadvantaged. This is because it is unlikely that even the most generously designed reform package will address all needs of all people, especially those who have historically been underserved.

Aside from persons outside of the new healthcare system, we believe that universal coverage will not necessarily mean universal access to healthcare services, nor will it mean universal care for all healthcare needs.

Persons who are poor and others currently going without healthcare services may fail to properly use the new system. Lack of an ability to cope with government bureaucracies and other struggles of daily living prevent many low income, low literacy and other troubled persons from taking advantage of programs available to them. Under-enrollment in the Special Supplemental Food Program for Women, Infants, and Children (WIC), Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and Medicaid give evidence of this phenomenon. It will be necessary for healthcare providers to reach out to these persons and families, enroll them into the healthcare system, and teach them how to use healthcare services in a more effective way than they have in the past.

Another problem that will persist for persons struggling with poverty and other hardships is that some providers may not wish to treat them, despite more equitable financing and other safeguards designed to avoid discrimination. Today, and predictably in the future, some providers will shun persons who are poor, are part of minority groups or have certain physical or mental disabilities. Their reason may be outright prejudice or the belief that such persons present language, literacy or other problems that take excessive resources.

In fact, our experience shows that many low income and multi-problem persons and families do require additional attention and services to adequately address their needs. We have found that other providers are not always prepared or willing to respond to these needs. Therefore, our communities will continue to need charitable healthcare organizations, driven by community needs, with an historical mission of service to the disenfranchised and particular expertise in reaching out and providing services to these populations.

It is also likely that enrolled persons will not have all health and health related needs met in the new system of care. Even a fairly comprehensive benefits package may not include needed over-the-counter medicines and appliances, transportation to health services, counselling, and some desired, but not life saving, procedures and treatments. Low income persons enrolled in the network are likely to continue to need some free and discounted services and supplies.

Hospitals' Charitable Purpose Continues: Community Benefit

The parallel definition of "charitable" is providing benefits to the broad community. This too, can characterize a tax-exempt healthcare organization in a reformed healthcare system because the community benefit role of not-for-profit hospitals goes beyond serving the poor and disadvantaged.

The Catholic Health Association believes that communities will continue to need the type of community benefit services not-for-profit tax exempt hospitals provide when they respond to community need and help build community-wide responses to those needs. Such services not only affect the poor and other special needs persons, but the broader community as well. These benefits to the broader community include policies and programs that

- Improve the health of persons in the community, and
- Improve the overall health of the community, preventing wide spread disease and injury and acting on societal problems that tend to cause disease and injury.

Not-for-profit tax exempt facilities will continue to work directly, in collaboration with partners in their health networks or other healthcare providers and with local and state health departments to address these community-wide issues. Some examples of community benefit services that will continue to be provided by not-for-profit healthcare organization include:

- Being part of community-wide efforts to decrease infant mortality and morbidity, to protect children against vaccine preventable disease, to address the problem of violence in the community and to help homeless families.

- Reaching out to minorities, the poor and other underserved persons, whether or not they are enrolled. This could include providing multi-lingual information on child health or offering employment opportunities to persons who are developmentally disabled.
- Implementing programs that promote health and avoid injury and illness through campaigns to decrease teen drinking, promoting the use of car seats for toddlers, and instituting surveillance systems for detection of unusual incidence of cancer, certain infection or other possible indications of systemic community health problems.

Summary

The welcome introduction of systemic healthcare reform with universal access to comprehensive healthcare services and improved delivery of services through integrated networks of providers will not eliminate the need for community oriented, charitable healthcare organizations.

Not-for-profit tax-exempt hospitals demonstrate that they fulfill a charitable purpose by continuing their founders' tradition of service, reaching out to the poor and underserved and by exhibiting concern for the broad community. As the healthcare system changes, this service orientation and community benefit role should continue to be a dominant characteristic not-for-profit hospitals and the American healthcare system and not-for-profit hospitals.

In conclusion, tax exempt; charitable healthcare organizations that are community oriented and hold to the principal "the poor have a moral priority" and are committed to responding to community need will continue to need and deserve tax exemption.



CATHOLIC HEALTH ASSOCIATION STANDARDS FOR COMMUNITY BENEFIT

As members of the Catholic Health Association of the United States, we share a historical mission and tradition of community service. In order to continue our tradition of providing benefit to the community, we affirm that:

1. The organization's mission statements and philosophy should reflect a commitment to benefit the community and that policies and practices be consistent with these documents including
 - Consideration of operational and policy decisions in light of their impact on the community served, especially the poor, the frail elderly, and the vulnerable
 - Adoption of charity care policies that are made public and are consistently applied
 - Incorporation of community healthcare needs into regular planning and budgeting processes
2. The governing body should adopt, make public, and implement a community benefit plan that
 - Defines the organization's mission and the community being served
 - Identifies unmet healthcare needs in the community, including needs of the poor, frail elderly, minorities, and other medically underserved and disadvantaged persons
 - Describes how the organization intends to take a leadership role in advocating community-wide responses to healthcare needs in the community
 - Describes how the organization intends to address, directly and in collaboration with physicians, other individuals, and organizations
 - Particular or unique healthcare problems of the community
 - Healthcare needs of the poor, the frail elderly, minorities, and other medically underserved and disadvantaged persons
3. The healthcare organization should provide community benefits to the poor and the broader community that are designed to
 - Comply with the community benefit plan
 - Improve health status in the community
 - Promote access to healthcare services for all persons in the community
 - Contain healthcare costs
4. The organization should make available to the public an annual community benefit report that describes the scope of community benefits provided directly and in collaboration with others.

Approved by CHA's Board of Trustees
April 1992



Shriners Hospitals

P.O. Box 43106, Atlanta, Georgia 30378 (404) 881-8292

GENE BRACEWELL
Past Imperial Potentate
President and Chairman



WRITTEN STATEMENT OF
GENE BRACEWELL
PRESIDENT AND CHAIRMAN OF THE BOARD OF TRUSTEES,
SHRINERS HOSPITALS FOR CRIPPLED CHILDREN
2900 ROCKY POINT DRIVE
TAMPA, FLORIDA 33607

BEFORE SUBCOMMITTEE ON OVERSIGHT,
COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

REGARDING TAX EXEMPT STATUS OF HOSPITALS
AND ESTABLISHMENT OF CHARITY CARE STANDARDS

UNDER PRESIDENT CLINTON'S
HEALTH SECURITY ACT (SEC. 7601)

NOVEMBER 9, 1993

Shriners Hospitals appreciate the opportunity to submit this written statement to the Subcommittee on Select Revenue Measures of the Committee on Ways and Means regarding the impact of health care reform on the 501(c)(3) status of charitable hospitals in general and the Shriners Hospitals in particular.

A hospital's tax-exempt status depends in part on the expectation that it provide care to the entire community and to those with limited ability to pay. Rev. Rul. 69-545, C.B. 1969-2, 117, amplfd. Rev. Rul. 83-157, C.B. 1983-2, 94. Health reform envisions the elimination of most uncompensated care. The President's Hospital Security Act propounds new standards for tax exemption in the case of all non-profit hospitals. We believe these new standards should not be approved without being thoroughly re-examined. Thus, the Subcommittee is now performing an important function especially because this country's only free hospital system seems unlikely to meet President Clinton's proposal without a wrenched interpretation of the words and phrases used in his proposal.

Section 7601 of the Health Security Act establishes new standards and states that for purposes of section 501(c)(3) of the Internal Revenue Code:

"the provision of health care services shall not be treated as an activity that accomplishes a charitable purpose unless the organization providing such services, on a periodic basis (no less frequently than annually), and with the participation of community representatives
 (1) assess the health care needs of its community, and
 (2) develops a plan to meet those needs."

If the Clinton conditional exemption had the terminology "for compensation" after the words "health care services," our IRS 501(c)(3) status would be protected.

If we were assured that such an insertion would occur, our immediate concern would be alleviated. However, it is likely that if Congress is going to continue special tax benefits for hospitals, whether for income taxes, bond financing, charitable deductions, or other financial assistance it will impose some requisite for some form of community service. For that reason, we share our thoughts on the present proposal and describe our provision of health care services and facilities for children in need.

The Shriners Hospitals believe that all 501(c)(3) hospitals have an obligation to share part of their resources to care for persons who are unable to care for themselves. We believe that tax exempt hospitals have a special duty to the community, and there is nothing unsound in demanding that non-profit hospitals give something of tangible value back to the community in exchange for the totality of financial benefits accruing from their tax-exempt status.¹

Unlike generic non-profit hospitals, which provide from 2.7 to 7.9 percent uncompensated care,² Shriners Hospitals provide 100 percent uncompensated care. Shriners Hospitals have always treated patients free but to be admitted, the children need to be needy (i.e., having parents or guardians who are not financially able to meet the costs of treatment without substantial hardship).

We accept no government, insurance or parental reimbursement, yet provide totally free care. In this respect, the Shriners Hospitals are completely unique in the United States. We believe we are the only free hospital system in this country. We achieve this status by spending earnings from our endowment (now approximating \$4 billion) acquired from the generosity of Americans as induced, in part, by satisfaction in helping needy children and by our Nation's charitable

¹ Statement of Gene Bracewell, President and Chairman of the Board of Trustees, Shriners Hospitals for Crippled Children printed in Hearing before the Committee on Ways and Means, House of Rep., 102d Cong., 1st Sess., on H.R. 790 and H.R. 1374, July 10, 1991 at 273-284, "Tax Exempt Status of Hospitals and Establishment of Charity Care Standards"

² United States General Accounting Office: Report to the Chairman, Select Committee on Aging, House of Representatives, GAO HRD 90-84: "Nonprofit Hospitals - Better Standards Needed for Tax Exemption" May, 1990. See also, "Nonprofit Hospitals: For Profit Ventures Pose Access and Capacity Problems" GAO HRD 93-124, July, 1993.

contribution deduction laws. "Dues" to our hospital corporation by 725,000 Shriners represent a considerable contribution to our \$300 million annual budget. Quite plainly if a hospital has endowment earnings to spend on patient care, it is less dependent on fees for services, whether paid by government, insurance or the patient. Current deduction incentives should be protected and enhanced to abate revenue demands from user fees.³

Our tax-exempt status is crucial to maintaining and increasing our services to children in need.⁴ The Health Security Act's 501(c)(3) standards are targeted at those hospitals which will stand to gain financially from the elimination of uncompensated care. It prejudices our hospital system by ignoring the per se benefits of free care.

Before 1969, although hospitals qualified for tax-exempt status as charitable organizations, the Service frequently challenged the exempt status of hospitals on the sole ground that the hospitals were accepting insufficient numbers of patients at no charge or at rates substantially below cost.⁵ According to the Ways and Means Committee, "[t]his has resulted in significant uncertainty as to the extent to which a hospital must accept patients who are unable to pay in order to retain its tax exempt status."⁶ This uncertainty, in turn, affects the continued ability of hospitals to draw the necessary public support by way of contributions to partially finance their capital needs and patient servicing.

As a result of this uncertainty, Congress approved an IRS ruling⁷ to the effect that hospitals were no longer subject to "requirements relating to caring for patients without charge or at rates below cost."

In previous testimony before the Ways and Means Committee,⁸ we suggested continuing a charitable requisite but supplementing it with a specific requirement that a defined amount or defined degree of no-cost or below cost care be rendered by the hospital to persons who are unable to pay as a way to avoid the uncertainty of pre-1969 law and assuring a clear measure of community benefit. This suggestion seems obsolete in light of President Clinton's almost universal coverage of all individuals with some form of insurance or health services.

While there may be some disagreement regarding what is required to meet a community's needs,⁹ there should be agreement that a hospital that provides 100 percent uncompensated care should retain its tax exemption

³ Bracewell Statement, note 1, at 283.

⁴ Bracewell Statement, note 1, at 281.

⁵ Cf. Rev. Rul. 136, C.B. 1953-2, 333, providing that 50% or more of the hospital care had to be paid for from contributions; see also, Rev. Rul. 55-564, C.B. 1955-2, 703, where IRS under some circumstances would not permit a hospital any fees or charges to gain a tax benefit.

⁶ See H. Rep. 91-413 (Part 1), Report of the Committee on Ways and Means on H.R. 13270 (Tax Reform Act of 1969), 91st Cong., 1st Sess., at 43.

⁷ Rev. Rul. 69-545, supra.

⁸ Bracewell statement, note 1, at 280-281.

⁹ See, e.g., Testimony of IRS Assistant Chief Counsel (Exempt Organizations), "Hospital Charity Care and Tax Exempt Status: Restoring the Commitment and Fairness", Hearing Before the Select Committee on Aging, House of Representative, 101st Cong., 2d Sess., June 28, 1990 at 57-73. Compare, Utah County v. Intermountain Health Care, Inc., 709 P.2d 265 (Utah 1985) (free care necessary for hospital tax exemption) City of Richmond v. Richmond Memorial Hospital, 116 S.E. 2d 79 (Va. 1960) (free care not necessary for hospital tax exemption).

regardless of any new standard for all other non-profit, corporate health care providers.

Shriners Hospitals operates 20 hospitals in 16 states with a total of 1050 beds. No hospital has an emergency room although each orthopaedic hospital has outpatient facilities for the care of children who are its patients (e.g., children with cerebral palsy or spina bifida or rickets). In the case of our orthopedic hospitals, we draw not only from the state of situs but on the average from 5 other states. Our burns units (Boston, Cincinnati, Galveston) draw nationwide and it is more likely than not, for all hospitals, that there would be more inpatients from outside the state of situs than from within the state. Quite practically, our hospitals serve the Nation as its community. Nevertheless, we do our own internal assessment of community needs based upon demographics and evaluation of the quality and cost of services rendered to patients, of our capital and equipment needs (unit by unit) and an assessment of the results of our research on burn treatment and orthopedic diseases (e.g., metabolic bone diseases). Realistically our community is represented by the Nation's neediest children and we have gone to extraordinary lengths to know what needs these children have so that our hospital facilities and personnel can offer the finest care available.

The Clinton proposal posits a "community" assessment of needs using "community representatives". First and foremost, that proposal discounts the strengths and values already developed by charitable providers to balance particular corporate purposes (teaching, research, treatment, etc.) based upon years of experience. It immediately demands that third parties ("community representatives") be given time, space and money to advise or require assistance at a time, place or to a degree that may be completely contrary to professional and corporate assessments of the same community.

Predicating tax exempt status on the degree and quality of community representation invites diversion of hospital resources to respond to demands of particular constituencies. Without giving the health care providers boundaries on how responsive they must be to "community representatives" demands, the governing boards of hospitals cannot exercise the prudence necessarily and historically expected of fiduciaries.

We urge the Subcommittee to make sure that any definition of charitable care using community standards must recognize a free hospital providing specialty care regardless of ability to pay is per se charitable and thus entitled to exemption under any revision of IRC 501(c)(3).

Alternatively, we suggest enactment of a new exemption provision, IRC 501(c)(26), which reads as follows:

"(26). Any hospital, clinic or fund organized and operated to provide hospital or medical care rendered without charge to the patient and is primarily supported by contributions from the general public, no part of the net earnings of which inures to the benefit of any private individual or shareholder".

Such an exemption¹⁰ would acknowledge that free care and public financial support are the paradigm for all non-profit health care providers. To further enhance the valuable tax incentives now available to charities, we suggest advancements of the sort noted below:

A. New Deduction Incentives for Outright Gifts

1. Appreciated property contributions of marketable securities (IRC Sec. 170(e)(5)) could be made to a IRC 501(c)(26) hospital (shortened to a "c-26") in excess of 30 percent of an individual donor's existing limitations (IRC Sec. 170(b)(1)(B)) to a maximum of 50 percent. Cash contributions to a c-26 fund in excess of the current 50 percent limitation of existing law (IRC Sec.

¹⁰ This proposal is modeled, in part, on 1939 IRC 1701(a)(1)(A). See, Rev. Rul. 136, supra.

170(b)(1)(A)), could be made up to an additional 25 percent of the adjusted gross income of a donor. Corporate donors could contribute up to 20 percent of taxable income, instead of the existing 10 percent limit. IRC 170(b)(2).

2. Cash contributions to a c-26, not in excess of \$250, could be treated as an above the line deduction (IRC Sec. 62(a)) but only if the contribution is made in cash, and only if the cancelled check is attached to the return in a formatting similar to that required by Section 155(a) of the DEFRA (1984), for attaching appraisal reports on gifts of property.

3. If any trust or estate made a charitable contribution in cash to a c-26 fund, it would be deductible, for income tax purposes, even if the contribution was not made "pursuant to the governing instrument." (IRC Sec. 642(c)(1)).

4. A private foundation's cash grant to a c-26 fund would be eligible for a 50 percent credit against its IRC Section 4940 tax, with the foundation credit not to exceed \$25,000 for any one year.

B. Deferred Giving - New Tax Incentives

1. A IRC 501(c)(26) hospital could become the sole beneficiary of an auxiliary pooled income fund where the actuarial valuation of the rate of return would be fixed at 3½ percent per year, regardless of the rate of return earned by the fund for the donor receiving income in return.

2. Such a c-26 pooled income fund could only be created with a term of years interest, not to exceed 10 years.

3. Charitable remainder unitrust or annuity trust valuations of a remainder interest passing to a 501 c-26 fund would use a 4½ percent interest assumption of the valuation of the charitable remainder instead of prevailing rates. No annuity or unitrust amount, payable to a private beneficiary, could exceed 7.0 percent, to preclude its abuse as an estate planning tool.

4. In the case of a deferred gift to a pooled income fund or a charitable remainder trust benefitting a c-26, where the income beneficiary dies within 24 months of the gift, the computation of the estate tax charitable contribution deduction would ignore the actuarial value of the decreased income beneficiary's life estate and use, instead, the actual value of the property passing to charity. Cf. Rev. Rul. 80-80, C.B. 1980-1, 194.

C. Form of Gift

1. Cash and marketable securities would be the only approved form of gift.



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